

**NURSES' VIEWS AND EXPERIENCES REGARDING  
IMPLEMENTATION OF RESULTS BASED FINANCING IN  
ZIMBABWE**

by

**PROSPER NYABANI**

submitted in accordance with the requirements

for the degree of

**MASTER OF PUBLIC HEALTH**

at the

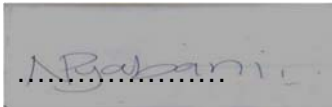
**UNIVERSITY OF SOUTH AFRICA**

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DECEMBER 2017

## DECLARATION

I declare that **NURSES' VIEWS AND EXPERIENCES REGARDING IMPLEMENTATION OF RESULTS BASED FINANCING IN ZIMBABWE** is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted before for any other degree at any other institution.

A rectangular box containing a handwritten signature in blue ink. The signature appears to be 'N. Nyabani' with a dotted line underneath it.

PROSPER NYABANI

December 2017

DATE

## **DEDICATION**

At some point I thought that the master stroke of submitting this masterpiece was a wild goose chase, therefore, this study is dedicated to my posterity, that they may live to appreciate and emulate a lifestyle of excellence and adventure with a view not to only leverage on, but also to surpass academic and professional precedence set by predecessors for the betterment of both present & future human generations in the society.

## **ACKNOWLEDGEMENTS**

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# **NURSES' VIEWS AND EXPERIENCES REGARDING IMPLEMENTATION OF RESULTS BASED FINANCING IN ZIMBABWE**

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## **ABSTRACT**

Results Based Financing (RBF) models are results oriented, linking performance indicators to incentives to motivate health workers to deliver quality care in anticipation of rewards attached to service delivery. The study sought to explore nurses' views and experiences regarding the implementation of RBF in Zimbabwe with the aim of recommending measures to strengthen the programme. The researcher used a qualitative, exploratory and descriptive design in this study. The population of this study comprised 21 nurses. Non-probability purposive sampling was used to select professional nurses involved in implementing RBF in Mrewa District, Mashonaland East Province, Zimbabwe. Data were collected through focus group discussions using an interview guide. Three (3) focus group discussions were conducted during this study, following a pilot study consisting of six (6) conveniently sampled nurses in Mashonaland East Province. Interviews were tape recorded and transcribed verbatim.

Permission to proceed with this study was granted by the Ministry of Health and Child Care and the University of South Africa. Measures to ensure credibility, dependability, conformability and transferability were followed. Data were analysed using Creswell's data analysis steps. Data were transcribed and thematically analysed, and emerging patterns were noted. The researcher examined these categories closely and compared them for similarities and differences, identifying the most frequent or significant codes in order to develop the main categories. These were summarised in narrative form. Four themes emerged from data: interpretation of RBF; role of nurses

in the implementation of RBF; evaluation of RBF; and strengthening implementation of RBF.

The study revealed various interpretations of RBF that converged to definitions of RBF in literature. Nurses viewed themselves as key and important players in the successful implementation of RBF. The successes and challenges of RBF were presented. Several measures that could strengthen the implementation of donor funds were highlighted, including subsidisation of low catchment health facilities, inclusion of district hospitals on the RBF programme, increasing financial autonomy of health facilities and the review of procurement guidelines. The study assumed that these measures will enhance nurses' work experience in donor funded health care delivery, and improve health outcomes.

*Keywords: Experiences, Implementation, Nurses, Results Based Financing (RBF), Views, Zimbabwe*

## TABLE OF CONTENTS

DECLARATION.....	i
DEDICATION .....	ii
ACKNOWLEDGEMENTS .....	iii
ABSTRACT .....	iv
LIST OF ABBREVIATIONS .....	xi

### CHAPTER 1 ORIENTATION TO THE STUDY

1.1 INTRODUCTION .....	1
1.2 RESEARCH PROBLEM.....	2
1.2.1 BACKGROUND TO THE PROBLEM .....	2
1.2.2 STATEMENT OF THE RESEARCH PROBLEM.....	3
1.3 PURPOSE OF THE STUDY .....	4
1.3.1 OBJECTIVES OF THE STUDY .....	4
1.4 RESEARCH QUESTIONS .....	5
1.5 SIGNIFICANCE OF THE STUDY .....	5
1.6 DEFINITION OF KEY CONCEPTS.....	5
1.7 RESEARCH METHODOLOGY .....	7
1.7.1 The research design .....	8
1.7.2 Population and sample .....	8
1.7.2.1 Population.....	8
1.7.2.2 Sampling and sample .....	8
1.8 THE RESEARCH SETTING.....	9
1.9 DATA COLLECTION.....	9
1.9.1 Data collection instrument and process .....	9
1.10 MEASURES TO ENSURE TRUSTWORTHINESS .....	10
1.11 DATA ANALYSIS .....	10
1.12 ETHICAL CONSIDERATIONS.....	10
1.13 SCOPE AND LIMITATIONS.....	11
1.14 STRUCTURE OF THE DISSERTATION .....	11

1.15	CONCLUSION.....	12
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## **CHAPTER 2**

### **LITERATURE REVIEW**

2.1	INTRODUCTION .....	13
2.2	THEORETICAL PERSPECTIVES ON HEALTH CARE FINANCING .....	13
2.2.1	Foreign aid in developing countries .....	14
2.3	EMPIRICAL UNDERSTANDING OF PERFORMANCE-BASED INCENTIVES (PBIs) .....	15
2.3.1	Results Based financing (RBF) .....	16
2.3.1.1	Relationship of regulator, purchaser and provider in RBF.....	17
2.4	HEALTH CARE SYSTEM IN ZIMBABWE .....	18
2.4.1	Organisation of health care in Zimbabwe .....	19
2.4.2	The RBF model in Zimbabwe .....	19
2.4.2.1	The Results Based Financing Cycle in Zimbabwe.....	20
2.5	EVALUATION OF RBF IMPLEMENTATION .....	21
2.5.1	The benefits of RBF .....	21
2.5.2	Challenges associated with the RBF model .....	22
2.6	CONCLUSION.....	23

## **CHAPTER 3**

### **RESEARCH DESIGN AND METHODOLOGY**

3.1	INTRODUCTION .....	24
3.2	PURPOSE OF THE STUDY .....	24
3.3	RESEARCH DESIGN.....	24
3.3.1	Qualitative research.....	25
3.3.2	Exploratory design .....	26
3.3.3	Descriptive .....	26
3.4	RESEARCH METHODS .....	27
3.4.1	Research setting.....	27
3.4.1.1	Map of Mashonaland East Province.....	28



3.4.2	Population .....	28
3.4.2.1	Criteria for inclusion in the study .....	28
3.4.2.2	Criteria for exclusion from the study .....	29
3.4.3	Sampling .....	29
3.4.4	Data collection .....	30
3.4.5	Preparing for focus groups interviews .....	31
3.4.6	Facilitation of focus group.....	32
3.5	DATA ANALYSIS .....	32
3.6	TRUSTWORTHINESS .....	33
3.7	ETHICAL CONSIDERATIONS.....	35
3.7.1	Permission .....	35
3.7.2	Informed consent .....	36
3.7.3	Self-determination.....	36
3.7.4	Privacy, anonymity and confidentiality.....	36
3.7.5	Protection from discomfort and harm .....	37
3.7.6	Fair selection and treatment .....	37
3.7.7	Scientific integrity of the study .....	37
3.8	CONCLUSION.....	38

## **CHAPTER 4**

### **PRESENTATION AND INTEGRATION OF FINDINGS WITH LITERATURE**

4.1	INTRODUCTION .....	39
4.2	ANALYSIS AND LITERATURE CONTROL.....	39
4.2.1	Participants' biographical information.....	39
4.3	THEMES.....	41
4.3.1	Theme 1: Interpretation of RBF .....	41
4.3.1.1	Subtheme 1.1: Meaning of RBF .....	42
4.3.1.2	Subtheme 1.2: RBF as Quality oriented financing model .....	45
4.3.2	Theme 2: Role of nurses in the implementation of RBF .....	49
4.3.2.1	Subtheme 2.1: Current clinical practices .....	49
4.3.2.2	Subtheme 2.2: Administrative functions.....	51
4.3.3	Theme 3: Evaluation of RBF .....	54

4.3.3.1 Subtheme 3.1: Perceived successes .....	54
4.3.3.2 Subtheme 3.2: Challenges in the implementation of RBF .....	57
4.3.4 Theme 4: Strengthening implementation of RBF .....	62
4.3.4.1 Subtheme 4.1: Improving the organisation of RBF .....	62
4.3.4.2 Subtheme 4.2: Reducing bureaucracy in operations .....	65
4.4 EMERGING RELEVANT OUTLIERS .....	67
4.5 CONCLUSION .....	67

## **CHAPTER 5**

### **INTERPRETATIONS, DISCUSSION OF RESEARCH FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS**

5.1 INTRODUCTION .....	69
5.2 RESEARCH METHOD AND DESIGN .....	69
5.3 FINDINGS AND CONCLUSIONS .....	69
5.3.1 Theme 1: Interpretation of RBF .....	70
5.3.1.1 Subtheme 1.1: Meaning of RBF .....	70
5.3.1.2 Subtheme 1.2: Quality oriented model .....	71
5.3.2 Theme 2: Role of nurses in the implementation of RBF .....	72
5.3.2.1 Subtheme 2.1: Current clinical practices .....	72
5.3.2.2 Subtheme 2.2: Administrative functions .....	73
5.3.3 Theme 3: Evaluation of RBF .....	74
5.3.3.1 Subtheme 3.1: Perceived successes .....	74
5.3.3.2 Subtheme 3.2: Challenges in the implementation of RBF .....	75
5.3.4 Theme 4: Strengthening implementation of RBF .....	76
5.3.4.1 Subtheme 4.1: Improving the organisation of RBF .....	77
5.3.4.2 Subtheme 4.2: Reducing bureaucracy in operations .....	78
5.4 RECOMMENDATIONS .....	78
5.4.1 Recommendations for policy related issues .....	78
5.4.2 Recommendations for further research .....	79
5.5 CONTRIBUTIONS OF THE STUDY .....	80
5.6 LIMITATIONS OF THE STUDY .....	80
5.7 CONCLUSION .....	81

LIST OF REFERENCES .....	78
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## FIGURES

Figure 2.1: Relationship of Regulator, Purchaser and Service Provider (Source: MoHCC 2017).....	17
Figure 2.2: Organisation of Health care in Zimbabwe (Source: MoHCC 2017) .....	19
Figure 2.3: Zimbabwe's RBF Cycle (Source: Gunda et al 2013).....	20
Figure 3.1: Map of Mashonaland East Province (Source: Murewa District Council: 2016).....	28

## TABLES

Table 3.1: Trustworthiness of the study .....	34
Table 4.1: Focus group biographical information.....	40
Table 4.2: Interpretation of RBF .....	42
Table 4.3: Role of nurses in the implementation of RBF .....	49
Table 4.4: Theme 3: Evaluation of RBF .....	54
Table 4.5: Theme 4: Strengthening implementation of RBF .....	62

## ANNEXURES

ANNEXURE A: UNIVERSITY OF SOUTH AFRICA ETHICAL CLEARANCE .....	87
ANNEXURE B: MEDICAL RESEARCH COUNCIL OF ZIMBABWE ETHICAL CLEARANCE CERTIFICATE.....	89
ANNEXURE C: LETTER REQUESTING PERMISSION FROM THE MINISTRY OF HEALTH AND CHILD WELFARE .....	90
ANNEXURE D: LETTER OF APPROVAL FROM THE MINISTRY OF HEALTH AND CHILD CARE .....	92
ANNEXURE E: INFORMED CONSENT FOR PARTICIPANTS .....	94
ANNEXURE F: INTERVIEW GUIDE FOCUS GROUP DISCUSSION .....	96

## LIST OF ABBREVIATIONS

ANC	Antenatal Care
ARVs	Anti Retrovirals
BP	Business Plan
BTC	Belgium Technical Corporation
CHCCs	Community Health Centre Committee
CCN	Council clinic nurse
CDVA	Contract Development and Verification Agency
CHNs	Community Health Nurses
DHE	District Health Executive
DHIS2	District Health Information System 2
DHMT	District Health Management Team
EHT	Environmental Health Technician
HCC	Health Centre Committee
HMIS	Health Management Information System
HTF	Health Transition Fund
IMR	Infant Mortality Ratio
LPU	Local Purchasing Unit
MDGs	Millennium Development Goals
MMR	Maternal Mortality Ratio
MNHC	Maternal and Neonatal Healthcare
MOH&CC	Ministry of Health and Child Care
NPA	National Purchasing Agency
OP	Operational Plans
OPD	Outpatients Department
PBIs	Performance Based Incentives
PCN	Primary Care Nurse
PHC	Primary health care
PIM	Project Implementation Manual
P4P	Pay for Performance
RBF	Results Based Financing
RHCs	Rural Health Clinics

RHFs	Rural Health Facilities
RGN	Registered General Nurse
RHFN	Rural Health Facility Nurse
SICC	Sister in Charge Community
WB	World Bank
WHO	World Health Organisation

# **CHAPTER 1**

## **ORIENTATION TO THE STUDY**

### **1.1 INTRODUCTION**

Health care financing and equity remains a global challenge for both developed and developing countries (World Bank 2013:17). One of the most affected continents is Africa, especially its Sub-Saharan Africa region, which is failing to translate rich natural resources to positive human development outcomes such as health care. As such, the continent is largely characterised by its heavy reliance on foreign aid, as well as huge dependence on out-of-pocket contributions and user fees (World Health Organisation (WHO) 2013:9).

According to Ministry of Health & Child Care (2017:18), Results Based Financing (RBF) model was adopted in Zimbabwe in 2011, with Cordaid implementing the model in 2 front-runner districts. This model was then further scaled up to 18 districts. The Cordaid programme is funded by the World Bank (World Bank 2014:13). In 2014, Crown Agents started implementing the Health Transition Fund Results Based Financing (HTF-RBF) programme in the remaining 42 districts in Zimbabwe, targeting rural health facilities. HTF-RBF is funded by a pool of 8 donors, namely UK Aid, European Union, Irish Aid, Canadian International Development Agency, Norwegian Embassy, Switzerland, WHO, and Department for International Development.

Nurses comprise the largest proportion, up to 80%, of the health workforce and are considered front line staff across the health continuum in most countries. In spite of the immense and significant role that nurses play in the health care system, their contribution to effective and efficient health care delivery systems is seldom acknowledged and recognised (Wilson, Whitaker & Whitford 2012:2).

This chapter provides an overview of the study's orientation, the background to the study, the problem statement, the purpose of the study, the significance of the study, and terminologies used in the study. The research questions, an introduction to the

methodology of the study, ethical considerations, and the scope and study limitations are also discussed.

## **1.2 RESEARCH PROBLEM**

A research problem is an area where there is an intellectual gap within the public health domain. Research is therefore conducted to generate knowledge in order to address the identified concern (Burn & Grove 2011:146).

### **1.2.1 BACKGROUND TO THE PROBLEM**

Due to weak economies, African governments' budgets are insufficient to address their social needs and are frequently exacerbated by corruption, weak public institutions and governance (WHO 2013:7). Generally, member states of the African region still fall short of meeting key health financing goals. In an attempt to assist third world countries to overcome these challenges and narrow the gap between developed and developing countries, there has been continuous capital inflow from developed nations to those in the third world; Africa included. However, there is evidence that decades of foreign aid have done little to better many African states.

Zimbabwe's health care financing model is largely out-of-pocket and donor aided to support the health systems (The National Health Strategy for Zimbabwe 2013:9). The RBF model was adopted in 2011 in Zimbabwe, with the primary objective to reduce maternal mortality to a double digit by 2020, and abolish user fees (Ministry of Health & Child Care (MoHCC) 2014:15). The RBF is currently implemented at rural health facilities and is supported by two separate development partners.

RBF models are results oriented, linking performance indicators to incentives to motivate health workers to deliver quality care in anticipation of rewards attached to service delivery. According to Basinga (2011:24), the RBF programme pays health facilities – Rural Health Clinics (RHC) – for outputs/results rather than inputs. The larger the volume of output (high utilisation), the larger the payment a facility receives. This is the hallmark of RBF, where income is linked to outputs.

Staff incentives earned differ according to their position in the Ministry of Health and Child Care's (MoHCC) hierarchy, and are paid in addition to fixed salaries. Many RBF programmes are targeted at Maternal Mortality Rate (MMR) reduction by improving the availability and access to maternal and child health care services (Cordaid 2013:4). The primary objective of RBF in Zimbabwe is to reduce maternal mortality to a double digit by 2020 and to abolish user fees (MoHCC 2014:15). The focus on maternal and child health imply greater involvement of nurses.

Nurses play important roles in the implementation of RBF; their views and experiences of the funding model are critical. Findings from a study conducted in Benin (Paul, Sossouhounto & Eclous' 2014:3) on health workers' perceptions of RBF indicate concerns over lack of programme ownership. Additionally, health workers working in areas supported by the British Corporation felt under paid compared to those working in districts supported by the World Bank (Paul et al 2014:6). The study also reports that health workers viewed the RBF programme as a stand-alone and dissociated model from other ongoing system reforms (Paul et al 2014:7).

In Zimbabwe, the RBF programme is being implemented in rural areas, with particular focus on primary health care facilities, which are solely manned by nurses. As such, nurses are the custodians of the RBF programme at operational level, owing to their day-to-day responsibilities of implementing the health financing model (MoHCC 2014:7). According to the Robert Wood Johnson Foundation (2015:3), nurses are well positioned to help meet the evolving needs of the health care system, as they play vital roles in strengthening primary care services, they deliver responsive care to the community, but most importantly, they provide seamless and coordinated care. They also take on emerging and dynamic roles as health systems as planners, organisers and innovators. Their perceptions, opinions and views become imperative to understand implementation of foreign aid in developing countries.

### **1.2.2 STATEMENT OF THE RESEARCH PROBLEM**

In an effort to improve health outcomes, equity, accountability, efficiency and performance of the health care system, Zimbabwe adopted a results-driven financing system.



The funding model is complex as it involves donors from different countries (MoHCC 2014:3). There are various conditions attached to the release of funds for health care delivery. In Zimbabwe, nurses play a significant role in the implementation of RBF. They develop operational/business plans and agree on terms with the Contract Development and Verification Agency (CDVA). They sign an annual contract on behalf of the health facility, agreeing to contractual obligations with the CDVA. Thereafter, the facility delivers quantity and quality health services as agreed upon. Nurses report on the statistics of services provided and the patients attended to. The CDVA verifies clinic registers, and payment to the facility is made based on verified data (Gunda, Mubaira & Maradzika 2014:3).

Clarke, Raphel and Disches (2008:11) indicate that nurses have been largely excluded from planning and implementing RBF programmes. There has not been any scientific study conducted to ascertain nurses' views and experiences regarding the RBF model in Zimbabwe. This indicated the need for a study to explore their views and experiences regarding implementation of the RBF model. The researcher believed that the success of any financing model is dependent on positive experiences and acceptance by the nurses.

### **1.3 PURPOSE OF THE STUDY**

The purpose of this study was to explore nurses' views and experiences regarding the implementation of RBF in Zimbabwe with the aim of recommending measures to strengthen the programme.

#### **1.3.1 OBJECTIVES OF THE STUDY**

In order to achieve the purpose of the study, the following specific objectives were formulated:

- Explore nurses' views regarding the organisation of RBF in Zimbabwe.
- Describe nurses' experiences in the implementation of RBF in Zimbabwe.

- Identify challenges in the implementation of the RBF programme.
- Recommend measures to improve implementation of the RBF.

## 1.4 RESEARCH QUESTIONS

The questions that directed the study were:

- What are the nurses' views regarding RBF in Zimbabwe?
- How do nurses experience the implementation of RBF in Zimbabwe?

## 1.5 SIGNIFICANCE OF THE STUDY

Acceptance and optimum functioning of nurses within the financing model could strengthen the health care system, and subsequently, the quality of patient care. The researcher's findings may contribute to the broader discourse on RBF and illuminate areas that need improvement. In addition, the findings could generate questions that will lead to further research on funding models in developing countries. The outcome of this study, which sought to explore the views and experiences of nurses about RBF, was recommendations for measures to strengthen the organisation and implementation of RBF in Zimbabwe.

## 1.6 DEFINITION OF KEY CONCEPTS

**Results Based Financing (RBF)** refers to funding for project implementation or service provision, where the principal (who provides the funding), pays the agent (who implements the project or provides the service) upon achieving predefined results (Grittner 2013:5). In this study, RBF refers to the processes of contracting health care service provision, and once achieved, payment of these predefined health services provided by nurses at rural health facilities implementing the RBF model, is made.

**Rural Health Facility (RHF)** refers to a facility where primary health care is provided (MoHCC 2014:6). In this study, RHF refers to a clinic where primary health care services are offered by the nursing staff implementing the RBF model and where specific indicators are tracked, verified and paid by the fund holder.

**Nurse:** The term refers to any person registered as a nurse or a midwife in terms of Zimbabwe's Nursing Act (Acts 1 of 1974 and 16 of 1999). In this study, a nurse is a professional who is contracted to offer health care service at a RHF implementing the RBF model in Zimbabwe.

**Views** are defined as one's perspective of a phenomenon (Hornby 2015:820). In this study, views refer to nurses' perspectives as they relate to the RBF model and their experiences of implementing the model.

**Experience:** The term refers to "practical understanding and knowledge gained from exposure" (Hornby 2015:517). In this study, experience indicates nurses' practical and day-to-day encounters with the processes involved in implementing the RBF model.

**Implementation** is a process to make something happen that has officially been decided (Hornby 2015:765). In this study, implementation means a process where nurses are using the RBF model to provide health care services, and this encompasses the business plan, the operational plan development, contracting, service delivery, verification, invoice submission, subsidy payments, disbursement, and subsidies utilisation.

**Challenges** refer to hurdles that hinder progress (World Bank 2014:9). In this study, challenges refer to difficulties and barriers that hinder the intended plans, strategies and processes associated with the successful implementation of RBF in Zimbabwe.

**Organisation** is defined as the structure or arrangement of elements (World Bank 2013:35). In this study, organisation refers to how the RBF is structured in Zimbabwe, particularly at the implementing level of RHF.

**Stakeholder:** The term denotes parties with vested interest in a programme (World Bank 2014:16). In this study, stakeholders are persons or institutions with vested interest in the RBF programme, such as nurses, the MoHCC, the purchasing agent, donors, and the community.

**Facility performance** is the measure of error rate in data reporting and the subsequent effect on facility earnings (MoHCC 2014:64). In this study

- high performing facilities refer to facilities that have an error rate within the 5% margin in data reporting;
- medium performing facilities refer to facilities that have an error rate between 5-10% in data reporting; and
- low performing facilities refer to facilities that have an error rate of more than 10% in data reporting.

This classification is based on the MoHCC Project Implementation Manual (2014:64).

## **1.7 RESEARCH METHODOLOGY**

A research methodology is a step by step chronological process for solving a problem, and encompass techniques used to structure the research study, and gather and analyse information (Polit & Beck 2012:391). Brink, Van der Walt and Van Rensburg (2012:199) state that the research methodology informs the reader of how the research was carried out, that is, the steps followed by the researcher to answer the research questions. This research study utilised a qualitative methodology. A full description of the research methodology is provided in Chapter 3.

### **1.7.1 The research design**

This research study was driven by qualitative methods and a qualitative, explorative and descriptive design was adopted. Qualitative research is generally exploratory, seeking to understand meaning. It allows respondents to express their views and experiences of the phenomenon under study from their own personal perspectives and viewpoints in an unlimited fashion (Streubert, Speziale & Carpenter 2011:22-23).

### **1.7.2 Population and sample**

#### **1.7.2.1 Population**

A population is a complete set of units that possess some common features that are of interest to the researcher (Brink et al 2014:216). The research population consisted of professional nurses providing care at council clinics and rural health facilities implementing the RBF model in Murewa district. The rationale for the criteria was to gather rich and comprehensive data from knowledge-rich participants in relation to the implementation of the RBF model.

#### **1.7.2.2 Sampling and sample**

Sampling is the process of selecting certain cases to represent the entire population so that inferences about the population can be made (Polit & Beck 2012:275). Non-probability sampling is a technique or procedure that is predominantly used in qualitative studies, ensuring that not every unit of a population has a chance to be selected to participate in the study (Grove, Gray & Burns 2015:263). According to De Vos, Strydom, Fouche and Delport (2014:391), purposive sampling is a non-probability sampling procedure, which is used to recruit participants based on the researcher's judgement. It was through purposive sampling that the researcher was able to select participants with special knowledge of and experience implementing RBF in rural clinics, and solicit rich and in-depth data on their views and experiences regarding implementation of the RBF model.

## **1.8 THE RESEARCH SETTING**

The study was conducted in Murewa district, situated in Mashonaland East Province, Zimbabwe. The estimated population is 199,607 (Murewa District Council 2016). Murewa has 23 RHF's implementing the RBF model. This study drew nurses working at council clinics and rural health facilities, implementing RBF, to participate in this research study.

## **1.9 DATA COLLECTION**

Data collection is a systematic way of collecting relevant information for the research purpose and objectives of the study. It deals with collecting data for the study (Brink et al 2012:148). This study made use of focus groups for data collection. This data collection method was appropriate for in-depth exploration and description of nurses' views and experiences regarding implementation of RBF in Zimbabwe, as it permitted participants to share their experiences in their own voices freely in a non-threatening environment.

### **1.9.1 Data collection instrument and process**

Data collection is a step by step chronological process to gather relevant information for the research purpose and objectives of the study. It involves acquiring the participants and gathering data for the study (Brink et al 2012:148). As mentioned earlier, this research study made use of focus groups for data collection.

Focus groups were ideal for this research study as they provided for group interaction among study participants and exploited the potential for greater insights to be developed and discussed. Focus groups were important because participants constituted a number of individuals who shared similar characteristics and experiences, hence it was desirable to collect the views and experiences within that population subgroup.

## **1.10 MEASURES TO ENSURE TRUSTWORTHINESS**

Trustworthiness relates to the levels of confidence qualitative researchers have in their data, evaluated based on the criteria of credibility, transferability, dependability and conformability in the study (Polit & Beck 2012:745).

## **1.11 DATA ANALYSIS**

Data analysis refers to ongoing processes which encompass continual reflection about the data, asking analytic questions, and making notes throughout the study. It is conducted simultaneously with data gathering, drawing interpretations, and writing reports (Creswell 2014:184). Brink et al (2012:193) advise that data in qualitative research is usually non-numerical, taking the form of written or audio-taped information. It was thus deemed appropriate for this study. During data analysis, the researcher followed the steps described in Creswell (2014:194).

## **1.12 ETHICAL CONSIDERATIONS**

Human subjects took part in this study, thus to ensure that their rights were protected, caution was exercised. Ethics constitute moral values concerned with the level to which research procedures align with the professional, legal, and social dictates of the study participants (Polit & Beck 2012:727). Permission to conduct the research was sought and granted from all relevant authorities. Ethical clearance to conduct the study was obtained from the University of South Africa, the Medical Research Council of Zimbabwe, and the MoHCC in Zimbabwe. This step was necessary to safeguard the rights and safety of the professional nurses who took part in this study. Ethical considerations are discussed in detail in Chapter 3 under beneficence, informed consent, the right to self-determination, the right to privacy, anonymity, and confidentiality.

### **1.13 SCOPE AND LIMITATIONS**

There are many aspects, stakeholders, and dynamics involved in the implementation of the RBF model in Zimbabwe. This study only focused on nurses' views and experiences regarding implementation of the RBF model in one district.

### **1.14 STRUCTURE OF THE DISSERTATION**

This research study constitutes five chapters. A brief description of each follows.

#### **Chapter 1: Orientation to the study**

This chapter presents the introduction and background to the study. It further describes the problem statement, purpose of the study, significance of the study, terminologies used in the study, and research questions. An introduction to the methodology of the study, ethical considerations, and the scope and limitations are also offered in this chapter.

#### **Chapter 2: Literature review**

In this chapter, a literature review on the broad theoretical perspectives of health care financing, and the implementation of RBF globally, in Africa, and in Zimbabwe is presented. Nurses and other health professionals' views and experiences are also discussed in detail.

#### **Chapter 3: Research design and methodology**

This chapter elaborates on the research methodology used in the study, including the research design, study population, sampling methods, and data collection methods. Additionally, it describes credibility, transferability, dependability and conformability, ethical considerations, and the data analysis method used.



## **Chapter 4: Presentation and integration of findings with literature**

Data analysis and research findings are presented in this chapter. Further, integration of the literature with findings is presented.

## **Chapter 5: Interpretations, discussion of research findings, conclusions, and recommendations**

In this chapter, interpretations, discussion and conclusions from the study, study limitations, and the recommendations are outlined.

### **1.15 CONCLUSION**

This chapter provided an overview of the research problem, the purpose and significance of the study, the research design and methodology, including the population, sample, data collection, analysis and ethical considerations. Key terms were defined, and a chapter outline of the study was provided. The next chapter presents the literature review.

## **CHAPTER 2**

### **LITERATURE REVIEW**

#### **2.1 INTRODUCTION**

In this chapter, broad theoretical perspectives on health care financing are described. The emphasis of this chapter is on foreign aid and financing models in developing countries. Polit and Beck (2012:61) argue that some qualitative researchers conduct literature reviews at the end of the study owing to the notion that reviews conducted prior the study potentially influence the research thought processes, whereas others argue that conducting prior reviews help them capitulate the research problem at hand. The literature review can be used to frame the problem in the first instance, and presenting it at the end of the study provides for juxtaposition to allow comparing and contrasting of findings of the qualitative research study against the body of knowledge already in existence (Polit & Beck 2012:95). In this chapter, only general perspectives are given to enable an understanding of the context of nurses' views and experiences.

#### **2.2 THEORETICAL PERSPECTIVES ON HEALTH CARE FINANCING**

Health care systems can be described using models of service delivery, financing, and economic policy (Kulesher & Forrestal 2014:127). Health care financing has recently received considerable research and policy attention in both developed and developing countries. Gilson (2016) claims that health care systems are complex and dynamic in nature. They are adaptive systems influenced by broader political and economic forces; as such, issues of recognition of context and complexity should be addressed in health systems strengthening. This is important as contextual factors may determine a financing model's level of success. Developing nations are faced with challenges of raising adequate resources to finance health care needs for all citizens (Ataguba & Akazil 2010:72). Therefore, the design and implementation of an adequate health financing system is essential.

Health care systems adopt different financing models such as national health systems, social insurance, or private insurance models. Within each model there are various

forms of financing including general taxation, specific taxation, and private financing. Most industrialised countries have established systems, while developing nations have developed a formal system of health delivery. It is rare to adequately explain a nation's health care system with just one model due to variations or categories within the health care system financing model (Kulesher & Forrester 2014:127). In low and middle-income countries, health care financing often involves a mix of direct and indirect models. Those that rely on input-based financing do not create strong enough incentives to deliver the sufficient quantity/quality of services. These models have long been proven to have some flaws and inefficiencies. RBF emerged as a project aiming to counteract these inefficiencies (Brenner, Muula, Robyn, Barnighausen, Sarker, Mathanga et al 2014:9).

### **2.2.1 Foreign aid in developing countries**

Foreign aid refers to funds, materials, or services given as support by governments, organisations or individuals in rich countries to help people in poor countries. The aid may be an investment in people (social services, such as health sectors, education and housing) or environmental protection and support for institutions involved in human development (Niyonkuru 2016:2).

Foreign aid injects the much-needed resources and economic incentives for supporting health care provision and is key in determining health systems' performance. Health financing and equity remains a global challenge for both developed and developing countries (Africa Health Forum 2013:17). One of the most affected continents is Africa, especially Sub-Saharan Africa, failing to translate rich natural resources to positive human development outcomes such as health care. Therefore, the continent is largely characterised by its heavy reliance on foreign aid as well as a significant dependence on out-of-pocket contributions and user fees (Klynveld Peat Marwick Goerdeler KPMG 2012:16).

There are various perspectives of donor funding in third world countries by developed states, regarding the scope and motives that drive donor spending. Swanson, Atun, Best, Betigere, Campos, Chunharas et al (2015:3) state that global health donors lack coordination and cooperation in assisting low income countries. They further posit that

donor focus is predominantly on clinical aspects rather than institutional and organisational capacity building (Swanson et al 2015:3), suggesting the need for holistic approaches in health systems strengthening. Zimbabwe's health care financing model is largely out-of-pocket and donor aided to support health systems (Ministry of Health & Child Care 2013:9). Donors now demand demonstrations of value for money for sustainable health systems, thus focussing on results (World Bank 2013:2).

The developing world has come under criticism for its lack of effectiveness and efficient resource utilisation. On account of weak economies, African governments' budgets are often insufficient to address their social needs, particularly in the health care and education sectors (KPMG Report 2012:7). Health spending in developing states has generally been very low, with the majority of member states in the African region of the WHO still falling short of meeting key health financing goals, as is the case with the Abuja Declaration's target of allocating 15% of government budgets to health care. To date, only three countries have realised this target in Africa (WHO 2013:4).

Health spending is low in Africa, yet it is much higher than that of South Asia. However, South Asia has better health outcomes than Africa. As such, Africa is in dire need of more finance for health, as well as results (Africa Health Forum 2013:20).

### **2.3 EMPIRICAL UNDERSTANDING OF PERFORMANCE-BASED INCENTIVES (PBIs)**

Performance-based incentives (PBIs) are defined as a set of rewards deemed to satisfy basic human needs and encourage employees to do their best, as well as increase the level of their competences and commitment to work. Incentives may take the form of prompt payment of salary, payment of bonuses, allowances, profit sharing, and rewards (Elumah, Ibrahim & Shobayo 2016:3).

PBIs take various forms, however, there are two distinctly common forms of PBI, namely, RBF and Conditional Cash Transfer (CCT). RBF programmes target supply and delivery of health care facilities by incentivising health care providers, either as

individuals or as health care facilities. CCT programmes target the demand for utilisation of health care services.

### **2.3.1 Results Based financing (RBF)**

Results Based Financing (RBF) is defined as a strategy that is used to link financing to predetermined results, with payment only made upon realisation of agreed upon results that are confirmed through a meticulous verification process (Africa Health Forum 2013:1).

Additionally, RBF encourages synergies with communities, thus strengthening local economies through multiplier effects. RBF is believed to be an exponent for primary health care and equity between the rich and the poor by improving access, availability and affordability (Gunda et al 2013:25).

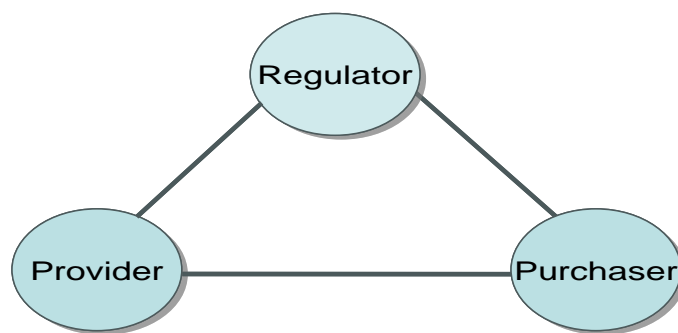
Grittner (2013:3) highlights that results based approaches have been a focus of recent discussions in international development. However, this discussion is not a completely new phenomenon. Instead, it has to be seen in the context of the aid-effectiveness agenda that started about 15 years ago, which has brought about international agreements such as the Paris Declaration on Aid Effectiveness in 2005, and the Accra Agenda for Action (Grittner 2013:3). As such, introducing and increasing utilisation of RBF is therefore a continuation and enforcement of international efforts to make development aid more effective. Proponents of RBF hope that it might deliver results that could not have been achieved by other aid modalities thus far.

RBF schemes have been introduced in more than 30 low and middle-income countries in the health sector with the aim of improving health care delivery. With the assistance of development partners, Burundi and Rwanda successfully pioneered implementing these schemes, inspiring fellow African countries to follow suit (Ye, Diboulo, Kagone, Sie, Sauerborn & Loukanova 2016:2).

RBF initiatives were developed in Asia, Cambodia around early 1990s and were later adopted in Africa – initially by Rwanda around 2002. In 2010, it was noted that 22 countries were planning to adopt the financing model. Of these 22 nations, Rwanda and Burundi had already adopted it as a national policy and scaled it up to national

level. Interestingly, the Central African Republic and Cameroon immediately followed suit (Sithole 2013:37). For a long time, RBF has been attributed to health systems strengthening in settings where it has been adopted. This is confirmed by Sieleumou, Tremblay and Taptue-Fotso (2017:3) who conducted a study in Cameroon and reported the positive impact of RBF, both on health care utilisation and quality of care. RBF has been celebrated as a financing model that increases access, availability and uptake of services. Successes have also been reported in Rwanda, including an increase in health care service uptake. Institutional/clinic deliveries increased by 23%, and preventative visits of children 23 months old or younger also increased by 56% since the inception of RBF (MoHCC 2017:17).

### **2.3.1.1 Relationship of regulator, purchaser and provider in RBF**



**Figure 2.1: Relationship of Regulator, Purchaser and Service Provider**  
(Source: MoHCC 2017)

Results based funding aims to encourage health systems in the developing countries by providing rewards directly linked to actions that contribute to positive health outcomes (Eichler, Agarwal, Askew, Iriate, Morgan & Watson 2013:538).

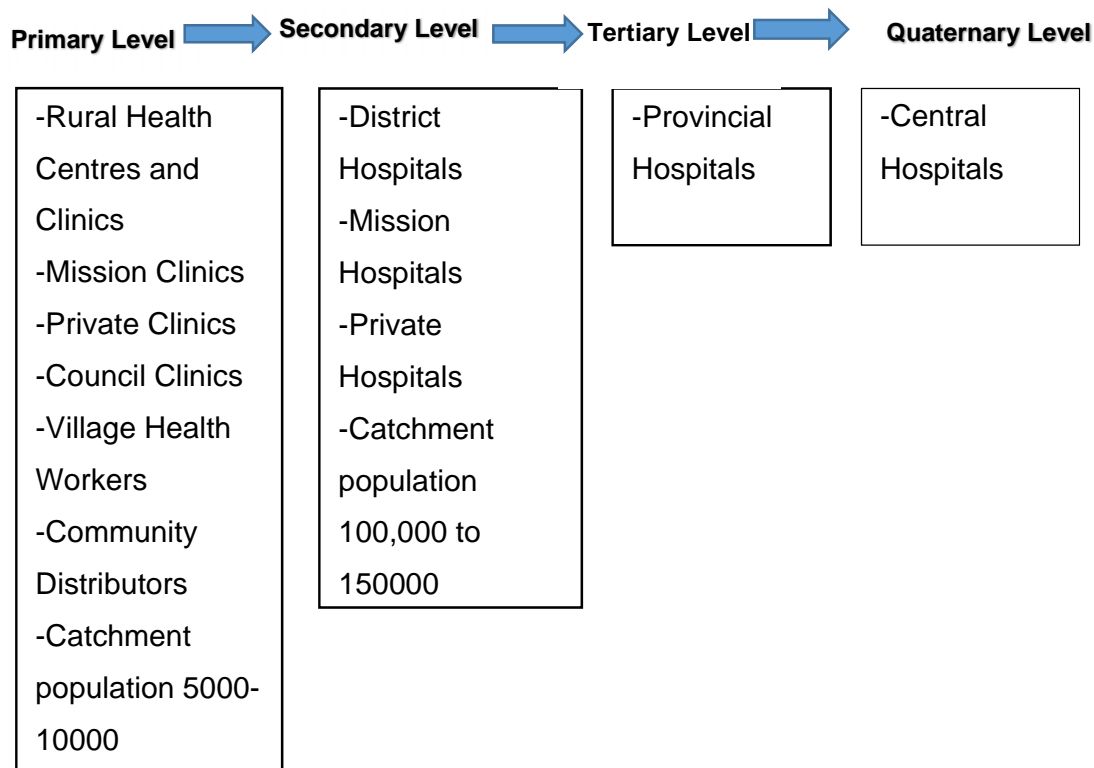
It is a form of funding for service provision, where the principal (donor or funder) provides funding and upon achieving predefined results pays the agent (service provider), who implements the project or provides the service (Grittner 2013:5). RBF differs from the traditional health financing models, such as input financing, that provides input prior to service. RBF starts with service provision which then informs the level of funding/financial rewards consistent with the service provided. There is separation of powers between the service provider (agent) and the donor, who is the funding agent as well as the regulator (government or parent ministry); this is a critical element for transparency. Moreover, RBF has elements of decentralisation and autonomy because service providers do their planning at local level, enjoying a certain measure of autonomy in the process. The monitoring and evaluation mechanisms in RBF are robust. This provides for balance and checks through the verification process, fostering credibility and authenticity. The service provider and the funder are bound by contractual obligations in their operations. Furthermore, the service provider is guided by a business/operational plan throughout the course of the year, which fosters corporate governance and planning in health care.

## **2.4 HEALTH CARE SYSTEM IN ZIMBABWE**

Zimbabwe's health care delivery system is multi-layered and organised at four levels of care, namely primary, secondary, tertiary, and quaternary. The model uses the primary health care approach of bringing basic care to the population through referrals at different levels. There are a total of 1634 primary health care facilities providing the point of entry to care. These include the rural health centres and clinics predominant in the rural areas, manned by professional nurses who provide basic health care services (MoHCC 2017:10). Where deemed necessary, patients are referred to the next level of care from primary level care to secondary level care, and this includes 60 district hospitals. Both doctors and nurses provide health care at district hospitals. Further complications are in turn referred to tertiary level care, and this level of care includes 8 provincial hospitals, where limited specialist services are provided by visiting specialists. The last level of care is quaternary; this constitutes the 4 central hospitals where a wide range of highly specialised services are provided by mostly resident specialists (MoHCC 2017:10).

The majority of health care facilities are directly or indirectly owned by government through local authorities, as is the case with council clinics. The private sector owns and controls the minority of health care facilities, primarily in the metropolitan settings. Churches/faith based institutions mainly own health care facilities in rural areas.

#### 2.4.1 Organisation of health care in Zimbabwe



**Figure 2.2: Organisation of Health care in Zimbabwe (Source: MoHCC 2017)**

#### 2.4.2 The RBF model in Zimbabwe

The RBF model was adopted in Zimbabwe in 2011 as a health financing strategy. The primary objective of RBF in Zimbabwe is to reduce maternal mortality to a double digit by 2020 and to abolish user fees (MoHCC 2014:15). This is in line with other developing countries that incorporate PBIs. The focus is on improving mother and child health (Eichler et al 2013:536).



### 2.4.2.1 The Results Based Financing Cycle in Zimbabwe



**Figure 2.3: Zimbabwe's RBF Cycle (Source: Gunda et al 2013)**

The RBF programme begins with the development of an annual business/operational plan between health facilities and the purchaser. Contracting between a purchaser and health facilities is guided by the agreed operational plan. The implementation of the RBF starts with facilities rendering services, and reporting outputs of services provided at the facility using T5 forms on a monthly basis. Verification of the reported statistics takes place on a monthly basis at the health facilities by verifiers against the reported statistics, with a maximum error rate of 5%. The facilities will not be paid for services provided if any error variance above the 5% occurs (World Bank 2014:23). Invoices are generated from verified data and are subsequently paid by the purchaser. The cycle begins again from the business plan to payment until the end of the year, when another operational plan is generated (Gunda et al 2013:54).

Globally, nurses are recognised as key stakeholders who contribute immensely to health care provision and health systems strengthening (Swanson et al 2015:2). National health systems largely depend on the nursing profession for health care services (The National Health Strategy for Zimbabwe 2013:12). In Zimbabwe, nurses play a pivotal role as frontline health care workers who provide primary health care services at rural health facilities contracted under the RBF programme (MoHCC 2014:17). However, nurses cannot work in isolation to make the financing model successful.

They need the involvement of other stakeholders, such as the community. Translating funding into health outputs requires a team that spans from national to community level, from officials in the national ministry to people in the supply chain for resources (Eichler et al 2013:537).

Nurses develop operational/business plans and agree on terms with the CDVA. They sign an annual contract on behalf of the health facility, agreeing to contractual obligations with the CDVA. Thereafter, the facility delivers quantity and quality health services as agreed upon. Nurses report the statistics of services provided and the patients attended to. The CDVA verifies clinic registers, and payment to the facility is made based on the verified data (Gunda et al 2014:3).

## **2.5 EVALUATION OF RBF IMPLEMENTATION**

### **2.5.1 The benefits of RBF**

RBF emphasises quality, accountability, and upskilling of health personnel. There have been good results reported in several developing countries. A qualitative study conducted by McCunes (2014:2) in Samburu, Kenya's rift valley, reported four positive factors which health workers attributed to performance based financing (PBF). These are:

- Firstly, financial compensation that staff receive as incentives through the RBF system. Such incentives have been found to contribute to the retention of health workers.
- Secondly, the RBF has brought about higher utilisation of health services and patient satisfaction with health care.
- Thirdly, the study identified improved working environments, which was associated with strong health worker motivation.

- The fourth factor reported by this study is increased collaboration, cohesion and team work at the health facility, consequently improving mentoring and supervision of clinic staff by the District Health Management Teams (DHMTs).

A study conducted in Burundi on physicians' and nurses' attitudes towards PBF indicated positive views that resulted in improved quality of care and increased utilisation of health care services (Rudasingwa & Uwizeye 2017:19). The authors, furthermore, highlight that the involvement of health care providers in all steps of PBF implementation was of paramount importance. Health professionals need to be skilled to enhance their confidence in new roles. Another study conducted in Zimbabwe by Makoni, Tsikirayi, Urombo and Vushoma (2014:3) reports that RBF has been effective in improving health worker motivation through staff incentive systems enshrined in the RBF's reward mechanism. This study also shows that staff attitudes towards work improved, and in turn, the quality of care also improved.

Other strengths of RBF were reported regarding improvements in record keeping. Health care record keeping and data management has been problematic in many developing nations, where the majority of health facilities still depend on paper documents as opposed to electronic medical records. However, a study conducted in Sierra Leone found that data reliability for RBF health facilities was higher than those of non-RBF health facilities. In addition, with RBF record keeping, 96% of patients earmarked for tracing were indeed identified (Schoffelen, van de Looij, Rusakaniko & Mhlanga 2016:77).

### **2.5.2 Challenges associated with the RBF model**

As with all health financing systems, RBF has been linked to several challenges. Some financial challenges associated with RBF involve delays in paying facility subsidies and staff incentives. These have the potential to dampen staff motivation and reduce the quality of health care services (McCunes 2014:3). A study conducted in Pakistan on a Pay for Performance (P4P) model, found that a dependence on donor aid is detrimental to the health system, and it was suggested to develop plans to mobilise health financing from domestic resources (Witter, Zulfigur, Javeed, Khan & Bari 2011:7).

Health care staff implementing RBF are expected to have various skills in financial management, and organisational management. In some instances, there is a knowledge deficit that hinders effective implementation of RBF (Paul et al 2014:7). The authors also indicated that RBF is not well integrated into the mainstream health care delivery system of recipient countries, and this was believed to be a major weakness. This may suggest the need to integrate RBF programmes into mainstream national health policies or strategies.

Witter et al (2011:4) sought to understand the experiences of health workers implementing RBF. They found that health practitioners were dissatisfied with the arrangement that do not allow them to engage in private practice once they serve at a P4P health facility, suggesting the need for flexible contractual obligations. Kavanagh, Cimiotti, Abusalem and Coty (2012:1) conducted a study in the United States of America on nursing-sensitive value-based purchasing and reported that participants were of the opinion that RBF programmes place higher demands and expectations on already understaffed clinicians.

## **2.6 CONCLUSION**

This chapter presented a brief overview of literature on theoretical perspectives on health care financing, foreign aid in developing countries, and empirical understanding of PBIs. Further, literature on Zimbabwe's health care system, the RBF model in Zimbabwe and evaluation of RBF was provided.

The next chapter will offer a discussion of the research design and research methods.

## **CHAPTER 3**

### **RESEARCH DESIGN AND METHODOLOGY**

#### **3.1 INTRODUCTION**

In this chapter, the research design and methodology are described. In addition, the research setting and population, data collection and analysis, trustworthiness, as well as ethical considerations, are defined in detail.

The research methodology comprises the logic underlying the research methods used during the study and justifies why certain methods or techniques were utilised (Burns & Grove 2011:253). The research methodology guides pathways in which meanings of data can be synthesised and ultimately be presented in a manner that meaningfully and significantly contributes to the body of knowledge (Babbie & Mouton 2012:75).

#### **3.2 PURPOSE OF THE STUDY**

The purpose of the study was to explore nurses' views and experiences regarding the implementation of RBF in Zimbabwe with the aim of recommending measures to strengthen the programme.

#### **3.3 RESEARCH DESIGN**

The research design refers to a plan or blueprint on how to conduct the study. It focuses on the end-product and logic of the study (Babbie & Mouton 2012:74). It maximises control over factors that could interfere with the validity of the findings, and guides the planning and implementation so that the purpose and objectives of the study are achieved (Burns & Grove 2011:253). This research study utilised a qualitative exploratory and descriptive design to explore nurses' views and experiences regarding implementation of RBF in Zimbabwe.

### **3.3.1 Qualitative research**

According to Babbie and Mouton (2012:646), qualitative researchers attempt to study human action from an insider's perspective. This requires an emic understanding of the situation; in this study referring to the interpretations of nurses regarding RBF as described from their point of view. Qualitative research is interpretive, humanistic and naturalistic, and is concerned with understanding the meaning of social interactions of those involved in the study (Grove et al 2015:20). In this study, the researcher depicted a holistic picture, analysed spoken words, and reported on the detailed opinions of nurses about their views and experiences regarding the organisation and implementation of RBF. The study was conducted in the nurses' rural clinics, which is a natural setting (Tappen 2011:37). A qualitative design was chosen because it allowed participating nurses to express themselves in their own voice from their own perspective, thus allowing the findings of the study to depict a true reflection of their views and experiences of implementing the RBF.

The objectives of this study were to explore nurses' views regarding the organisation of RBF in Zimbabwe, to describe their experiences of its implementation, to identify its challenges, and to recommend measures to improve the implementation. Therefore, it was concluded that a qualitative approach would be most appropriate to obtain more knowledge and understanding of the RBF model in Zimbabwe.

The researcher used unstructured data collection approaches such as semi-structured interviews using focus groups. An interview guide was developed based on the study objectives. The rationale for these approaches is that they allow the researcher to build rapport and eliminate any potential hindrances to access the insiders' opinions (Streubert et al 2011:22). In this study, the researcher built a trusting relationship with the participants by providing them with all the details pertaining to the study, including its benefits and purpose. As such, this approach allowed the researcher to gain an in-depth understanding of the views, experiences and challenges associated with RBF implementation.

Qualitative approaches assume that subjectivity is essential for the understanding of participants' human experiences (Brink et al 2012:11).

This approach assisted the researcher to make representations based on the nurses' interpretations and understanding of the implementation of the RBF model in Zimbabwe. The qualitative method also enabled the researcher to maintain direct contact with the nurses to capture and analyse data as it emerged. Babbie and Mouton (2012:292) indicate that focus group interviews create meaning when the participants engage in discussions where evidence of similarities and differences can be identified. The research questions lent themselves to a qualitative study, which was exploratory and descriptive.

### **3.3.2 Exploratory design**

Qualitative research is exploratory; it seeks to find meaning and allow for probing. This enabled the nurses to give their viewpoints and experiences concerning RBF implementation (Tappen 2011:67). Little was known about nurses' views and experiences regarding RBF implementation, even though this financing model has been implemented since 2011 in Zimbabwe. By using an explorative design, the nurses were able to express their thoughts and experiences, and the researcher uncovered new insights into and understanding of the organisation and operations of RBF.

The design was appropriate for the research study as it allowed the researcher to design facilitative approaches to elicit rich information from the nurses regarding RBF implementation. When little is known about a phenomenon, exploratory research is carried out with the intention to understand its full nature. It helps the researcher to answer the research questions of the study. Additionally, it provides the researcher with the information needed to achieve the purpose of the study (Grove et al 2015:77).

### **3.3.3 Descriptive**

The purpose of description is to communicate accurately the extent, variations and importance of a situation regarding the phenomenon being studied (Tappen 2011:78). Descriptive designs pay attention to how and why questions, to depict a detailed and accurate description of the phenomenon (De Vos et al 2014:96).

A detailed and accurate description of nurses' views and experiences of RBF implementation was provided in this study. This design enabled the researcher to discover new meaning, describe what exists, the contexts, and categorise information in a real world setting (Grove et al 2015:33). Description provides for the research questions to be answered and presents a factual account of what is happening on the ground (Saldana 2011:29).

The rationale for using a descriptive design was to describe the nurses' views and experiences of RBF implementation in a way that allowed full description of RBF, including their recommendations. The researcher formulated central and probing questions to comprehend the functioning of RBF from the nurses' perspectives.

### **3.4 RESEARCH METHODS**

Research methodology refers to a guided investigation and evaluation of the means of gathering and analysing data (Babbie & Mouton 2012:89). It comprises the research setting, population, and sampling of the study.

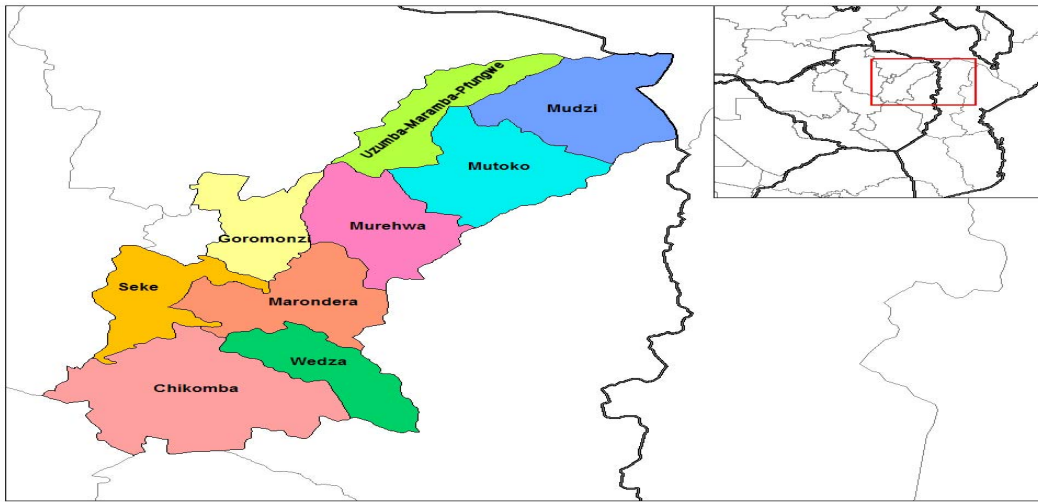
#### **3.4.1 Research setting**

According to Brink et al (2012:59), the research setting refers to a specific place where data pertaining to the phenomenon under observation is collected. The study was conducted in a natural setting in Murewa district.

Murewa is one of the 8 districts located in Mashonaland East Province, Zimbabwe. It has 23 rural health facilities implementing the RBF model. Murewa district was selected because of the researcher's involvement in rural health care delivery in this district. Twenty-one health facilities, comprising 9 council clinics and 12 rural health facilities, were represented in this research study. The government directly governs rural health facilities, whereas, local authorities, are responsible for council clinics.



### 3.4.1.1 Map of Mashonaland East Province



**Figure 3.1: Map of Mashonaland East Province (Source: Murewa District Council: 2016)**

### 3.4.2 Population

Grove et al (2015:46) posit that the population includes all elements that meet certain set criteria for inclusion in a study.

The target population for this study included professional nurses who were working in 9 council clinics and 12 rural health facilities implementing the RBF model in Murewa district.

#### 3.4.2.1 Criteria for inclusion in the study

The inclusion criteria refer to features that units of the population must possess in order to be included as participants of the study (Grove et al 2015:505). The rationale for the criteria was to gather rich and comprehensive data from knowledge-rich participants in relation to the implementation of the RBF model.

Eligibility criteria for inclusion in the study were as follows:

- Participants had to be nurses with minimum general nursing training

- Participating nurses had to be directly involved in the implementation of RBF for at least a year.
- Nurses working day shifts during the time of the study were included in the study.

#### **3.4.2.2 Criteria for exclusion from the study**

Nurses who had less than a year's experience in RBF were excluded from the study.

#### **3.4.3 Sampling**

According to Brink et al (2012:132), sampling entails the researcher selecting a sample from a population to obtain data that is a true representation of the entire population. A sample is a subset of the entire population selected for a specific study and the members of a sample constitute the study units (Grove et al 2015:46). In this study, the researcher selected nurses based on their knowledge of and experience in implementing the RBF model (Brink et al 2012:140).

The study utilised non-probability purposive sampling. This entails that not every element of the population has a chance to be selected to take part in the study (Grove et al 2015:263). This technique has the advantage of selectively targeting participants with the greatest potential of contributing meaningfully to the study, thus saving time and resources. Non-probability sampling was appropriate for the study as it allowed the researcher to interview nurses who had special knowledge on RBF implementation in Zimbabwe.

Purposive sampling, also known as judgemental sampling, is a process where participants are selected for a specific purpose, based on the judgement of the researcher (Polit & Beck 2010:312). The goal in this study was to recruit participants who were knowledge-rich on the topic.

They were thus better placed to provide rich data on RBF implementation at rural health facilities in Zimbabwe (Brink et al 2012:139).

From the 23 health facilities implementing RBF in Murewa, 21 participating nurses were recruited from 9 council clinics and 12 rural health facilities. This allowed diverse variations and identification of common patterns between different types of health facilities implementing RBF.

Non-probability, purposive sampling was appropriate for this study, as it allowed the researcher to interview nurses in their work environment. In addition, these nurses were directly involved in the RBF programme, and they were available and willing to share their views and experiences regarding implementation of the RBF programme.

#### **3.4.4 Data collection**

According to Polit and Beck (2012:725), data collection is a way of collecting information pertaining to the research purpose, objectives and research questions. An unstructured approach, using focus groups, was used to collect data from 21 participating nurses drawn from 9 council clinics and 12 rural health facilities. Focus groups are used to explore different topics in diverse settings in nursing (Streubert et al 2011:38). The advantage of focus groups is that the views can be compared between participants.

In this study, the researcher had prolonged contact/interviews with participants until data saturation. Data saturation occurs when additional sampling yields no additional new information, and information that emerges becomes repetitive (LoBiondo-Wood & Haber 2010:236). Participants had an opportunity to elaborate on their interpretation of RBF implementation in Zimbabwe. The focus group allowed nurses to share their views and experiences in a relaxed and non-threatening environment. Discussions were encouraged through probing questions that enabled the researcher to uncover in-depth information about RBF. Ideally, focus groups are suitable where group interaction among participants has the potential to yield greater insights which can be developed through discussion.

Focus groups are also important where a number of informants share similar experiences, and when it is desirable to collect the views and experiences of several people within a population subgroup. The use of focus groups overcame the problems of resource constraints and geographical spread in Murewa district. Streubert et al (2011:37-38) posit that focus groups are appropriate for qualitative data collection because they have the advantages of being inexpensive, flexible, motivating, assist in information recall, and allow for rich data to be collected.

In this study, the researcher was the main data collector, assisted by a public health professional colleague who acted as a scribe.

#### **3.4.5 Preparing for focus groups interviews**

To ensure a standardised data collection process for the various focus group discussions, an interview guide was designed with a view to primarily capture participants' demographics in section A and data that responds to the research questions in section B (refer to annexure F page 96). A pilot study consisting of six conveniently sampled nurses was used to pre-test the suitability of the interview guide, modifications were effected accordingly. The participants were contacted and informed of the purpose, title of the study, date and location of focus group interviews. The boardroom used for nurses' monthly review meetings was selected because of its location and convenience. To ensure a relaxed environment, refreshments such as snacks and juice were arranged for the participants. A biographic form was prepared for participants to complete their biographic information. The scribe was notified well in advance of her role, the date and venue for the focus group interviews. An audio recorder was prepared to record the focus group interviews. To avoid disruption of health care service provision at rural health facilities, the focus groups were scheduled over the weekends, during which time health facilities are far less busy than during midweek and nurses from nearby health facilities were asked through authorities to be on stand by for emergencies that could arise for health facilities that were manned by a single nurse who participated in this study.

### **3.4.6 Facilitation of focus group**

Twenty-one nurses participated in the focus group discussions. One focus group comprised of eight participants, the second one six, and the third had seven participants. The nurses who met the inclusion criteria and who were willing to participate in the study were given consent forms and biographic forms that outlined the conditions for participation. The purpose of the study was discussed with the participants, and they were informed of their rights (refer to Annexure E). All nurses signed the consent form and the interviews were audio recorded to capture their real 'voices'. To ensure equal participation, a horseshoe seating arrangement was used during the interviews. The role of the scribe and the use of the audio recorder was explained to participants before the focus group interviews commenced.

To minimise disturbances, a sign "meeting in progress, please do not disturb", was put on the door of the boardroom. The researcher introduced himself and the scribe. Participants had the opportunity to introduce themselves to the group. Ground rules relating to the use of mobile phones and ensuring that one person speak at a time, were emphasised. Participants were again reminded of their right to withdraw from the research at any stage and to report any feelings of distress. Measures were taken to ensure there was an adequate number of participants in each group, and balanced participation.

In total 3 focus group interviews were conducted until data saturation was reached, when no new information was obtained from the study participants.

## **3.5 DATA ANALYSIS**

Creswell (2014:184) advises that data analysis is an ongoing process which calls for continual reflection about the data, asking analytic questions and writing memos throughout the research study. It is conducted simultaneously with data collection, progressively focussing, making notes, and drawing interpretations. Data in qualitative research is non-numerical and is generally in the form of written narratives (Brink et al 2012:193).

A thematic analysis was used to review the data to identify common issues that recur. The research analysis steps described in Creswell (2014:194) were followed. These are:

- The researcher studied the recordings from the focus groups and transcribed them.
- The researcher repeatedly read the written data to immerse himself in it.
- Sections of the data which appeared to be informants' distinct views were highlighted with coloured pens to develop broad topics which were abbreviated into the predetermined codes.
- Coded sections were repeatedly read to mark sections that align with the topic. These were then cut and pasted, and similar data from the quotes were grouped and classified to develop themes, subthemes and categories.
- Data were summarised using codes, and compared to establish relationships among different categories.
- The themes were consolidated to develop meanings.

### **3.6 TRUSTWORTHINESS**

Trustworthiness measures confidence levels of qualitative researchers regarding their data, evaluated based on the criteria of credibility, transferability, dependability and conformability (Polit & Beck 2012:745).

**Table 3.1: Trustworthiness of the study**

<b>Criteria for trustworthiness</b>	<b>Current research study</b>
<b>Credibility:</b> Credibility entails confidence in the truth of the data and subsequent interpretations (Polit & Beck 2012:724). It is through prolonged engagement, persistent observation, peer debriefing, member checks, negative case analysis, and referral adequacy that confidence in the truth of the findings can be established (Polit & Beck 2010:492).	The researcher enhanced credibility by prolonged engagement with participants during focus groups interviews until data saturation occurred. Scripts were read at the end of each focus group for informants to confirm that they were a true reflection of their views and experiences expressed during the focus groups. Additionally, the researcher made an effort to put aside his own preconceived ideas and personal biases, by being scientifically objective and following strict research guidelines. Furthermore, the researcher is trained in health systems and has experience implementing health financing models.
<b>Dependability</b> refers to the provision of evidence that leads to similar findings if the research study is repeated with the same participants in the same context using the same methods (Polit & Beck 2010:492).	An audit trail was created so that the supervisor could cross-check both the research methods and the researcher's interpretations. A full description of the research design, methods and its implementation, data collection process and procedures used by the researcher in the study were provided. Nurses' verbatim accounts and the use of an audio recorder enhanced dependability.
<b>Conformability:</b> According to Polit and Beck (2010:492), conformability entails that data collected and study findings must reflect the views and experiences of study participants and not the researcher's perceptions.	Comprehensive data was compiled according to themes and subthemes and preliminary analysis was performed to represent participants' views and personal experiences. An audit trail was created by way of recordings, thus ensuring transparency. The researcher also sought confirmation from the participants that the interpretations were a true reflection of their views

Criteria for trustworthiness	Current research study
	and experiences regarding implementation of the RBF model. Recordings and transcriptions were juxtaposed to enhance conformability.
<b>Transferability</b> is the likelihood of research findings being generalised in other contexts or with other participants. The researcher's primary concern is in defining observations and not generalising the study findings. Whether or not findings are transferable, is the prerogative of potential users, not the researcher's (Polit & Beck 2010:492).	Recommendations for programme improvement emanating from understanding nurses' views and experiences regarding the implementation of RBF were specific to Murewa district. However, owing to detailed descriptions of the research methods and data, the recommendations could be implemented in other districts implementing RBF in Zimbabwe.

### 3.7 ETHICAL CONSIDERATIONS

Ethics is a branch of philosophy interested in protecting the human rights of study participants. Self-determination, privacy, anonymity and confidentiality, fair selection, fair treatment, and protection from discomfort and harm constitutes human rights (Grove et al 2015:100).

The ethical considerations observed during this study are discussed next.

#### 3.7.1 Permission

The researcher requested and obtained permission from the Higher Degrees Committee of the Department of Health Studies, University of South Africa (refer to Annexure A), the Medical Research Council of Zimbabwe (refer to Annexures B), and the MoHCC (refer to Annexure D).



### **3.7.2 Informed consent**

Polit and Beck (2012:730) indicate that informed consent is an ethical principle that requires researchers to obtain the voluntary participation of subjects, following information given to them of potential risks and benefits. The researcher informed the participants of the nature and purpose of the study (refer to Annexure E). They were made aware that participation was voluntary. The researcher assured participants that data collected will be used for research purposes only. Consent was obtained from selected participants after the MoHCC granted permission.

### **3.7.3 Self-determination**

Rights of respondents to self-determination is based on the principle of respect for human beings. Subjects have the right to decide whether or not to participate in a study without repercussions, may withdraw from the study at any time, may refuse to give information, and may seek clarification on the purpose of the study (Brink et al 2012:35).

The researcher took the time to explain the purpose of the study and made the participants aware that they have a right to choose to participate or withdraw at any time without any penalties.

### **3.7.4 Privacy, anonymity and confidentiality**

Privacy entails limiting access to authorised parties only to listen and make sense of information collected during the study. In this study, nurses were told of their rights to decide on the type of information they were willing or comfortable to share with the researcher. However, for the purpose of depth and good understanding of their views and experiences, they were requested to share any useful information.

Anonymity means that the individual identities of research participants cannot be associated with their responses, even by the researcher (LoBiondo-Wood & Haber 2010:252). Anonymity is guaranteed when study participants' responses cannot be traced to their identities in any way (Burns et al 2011:533). To ensure anonymity in

this study, participants were assigned code numbers during data collection and report writing.

Burns and Grove (2011:533) state that confidentiality entails that individual identities of participants cannot be linked to the responses they provided in the study. Only authorised persons had access to data and focus group data were analysed as a group, thus, protecting individual participants' identities.

### **3.7.5 Protection from discomfort and harm**

Beneficence is an ethical principle that seeks to optimise gains for study participants and prevent harm (Polit & Beck 2012:720). In this study, the researcher followed the principle of beneficence, which has different dimension including freedom from harm and exploitation.

### **3.7.6 Fair selection and treatment**

The right of participants to fair selection and treatment is based on the ethical principle of justice, which indicates that the researcher must select the study population with fairness. The participants should be selected for reasons directly related to research problems (Brink et al 2012:36).

The researcher fairly selected study participants, solely for reasons directly related to their views and experiences regarding implementation of RBF in Zimbabwe, not merely because they were readily available. The participants were treated fairly and with respect.

### **3.7.7 Scientific integrity of the study**

According to Brink et al (2012:43), scientific integrity constitutes honest research conduct generally deemed acceptable within the scientific community at all stages of research. The researcher adhered to high ethical standards. Compliance with measures to enhance trustworthiness fostered the study's scientific integrity.

Furthermore, the researcher acknowledged all intellectual property that was used in this research. Additionally, study findings were fully and correctly presented.

### **3.8 CONCLUSION**

This chapter presented the research design and methodology, as well as the population, sampling, data collection and analysis. Furthermore, the ethical considerations and measures to ensure trustworthiness of the study were discussed. Chapter 4 elaborates on the findings of the research study.

## **CHAPTER 4**

### **PRESENTATION AND INTEGRATION OF FINDINGS WITH LITERATURE**

#### **4.1 INTRODUCTION**

This chapter presents the findings of the study and literature that support the findings. Themes, subthemes and categories that emerged are presented and substantiated by verbatim statements. In qualitative studies, the researcher juxtaposes the research findings of the study and literature as the basis for contrasting and comparing findings (Brink et al 2012:99; Creswell 2014:29-30). The objectives of the study were to explore nurses' views regarding the organisation of RBF programme in Zimbabwe, describe nurses' experiences of the implementation of RBF in Zimbabwe, identify the challenges in the implementation of the RBF programme, and recommend measures to improve implementation of the RBF. Data from all three focus groups were merged and analysed as a whole.

#### **4.2 ANALYSIS AND LITERATURE CONTROL**

##### **4.2.1 Participants' biographical information**

Table 4.1 provides the combined biographical data that describe the specific attributes of the participants. It is a depiction of participants' gender, age, RBF training, years of experience as a registered nurse, and years of experience implementing RBF.

**Table 4.1: Focus group biographical information**

<b>Parameter</b>	<b>Focus Group 1 N=8</b>	<b>Focus Group 2 N=6</b>	<b>Focus Group 3 N=7</b>
<b>Gender</b>	Male = 0 Female = 8	Male = 3 Female = 3	Male = 2 Female = 5
<b>Age</b>	21-30yrs = 1 31-40yrs = 4 41-50yrs = 2 51-60yrs = 1	21-30yrs = 0 31-40yrs = 3 41-50yrs = 3 51-60yrs = 0	21-30yrs = 0 31-40yrs = 3 41-50yrs = 4 51-60yrs = 0
<b>RBF training</b>	Yes = 5 No = 3	Yes = 0 No = 6	Yes = 4 No = 3
<b>Type of facility</b>	Council Clinic=2 Rural Health Facility=6	Council Clinic=4 Rural Health Facility =2	Council Clinic=4 Rural Health Facility=3
<b>Years of experience as a nurse</b>	0-5yrs = 4 6-10yrs = 3 11-15yrs = 1 16-20yrs = 0 More than 20yrs = 0	0-5yrs = 3 6-10yrs = 3 11-15yrs = 0 16-20yrs = 0 More than 20yrs = 0	0-5yrs = 0 6-10yrs = 3 11-15yrs = 2 16-20yrs = 2 More than 20yrs = 0
<b>Years of experience implementing RBF</b>	0-1yr = 0 2-3yrs = 4 3-4yrs = 4 More than 4yrs = 0	0-1yr = 2 2-3yrs = 1 3-4yrs = 3 More than 4yrs = 0	0-1yr = 1 2-3yrs = 0 3-4yrs = 0 More than 4yrs = 6

A total of twenty-one nurses participated in the focus group discussions, of whom five were male and sixteen were female. The average age of participants was thirty-seven years. Nine nurses were trained in RBF and twelve were untrained. As the table shows, the average years of experience as a professional nurse was ten years. The average years of experience in implementing RBF was three years. It was assumed that the participants' years of experience working in the RBF context would provide more in-depth knowledge, therefore this information was deemed important.

Of the twenty one participants, ten were from council clinics and eleven were employed in rural health facilities.

### **4.3 THEMES**

According to LoBiondo-Wood and Haber (2010:128), a theme is defined as a label that represents a way of describing large quantities of data in a condensed format. Four themes with associated categories emerged from the data collected during the three focus groups. These were:

- Theme 1: Interpretation of RBF
- Theme 2: Role of nurses in the implementation of RBF
- Theme 3: Evaluation of RBF
- Theme 4: Strengthening implementation of RBF

#### **4.3.1 Theme 1: Interpretation of RBF**

Sub-Saharan Africa is characterised by heavy reliance on foreign aid in health care delivery (KPMG 2012:16). As such, it was important to establish how the recipients of donor funds viewed or understood the healthcare funding model applied.

In Theme 1, interpretation of RBF, two subthemes emerged. These were: the meaning of RBF, and RBF as a quality oriented financing model. The subthemes and categories of Theme 1 are presented in Table 4.2:

**Table 4.2: Interpretation of RBF**

Theme	Subtheme	Category
<b>Theme 1: Interpretation of RBF</b>	Meaning of RBF	<ul style="list-style-type: none"><li>• Link of results to payments</li><li>• Focus on maternal and child health</li><li>• Proper documentation</li><li>• Client-centred care</li></ul>
	RBF as a quality oriented financing model	<ul style="list-style-type: none"><li>• Verification</li><li>• Reimbursement structure</li><li>• Indicator-based payment structure</li></ul>

#### **4.3.1.1 Subtheme 1.1: Meaning of RBF**

In this subtheme, four categories emerged: the link of results to payments, focus on maternal and child health, proper documentation, and client-centred care. Each will be discussed in the following sections.

Both council clinics and rural health facilities were represented in this study and their contributions are indicated in the quotations from the participants (Whereas CCN refers to Council Clinic Nurse, RHFN refers to Rural Health Facility Nurse):

##### **a) Category 1.1.1: Link of results to payment**

Participants elaborated on their interpretations and understanding of RBF. They presented various views. However, there was some general convergence in their interpretations. They described RBF as a model of financing that is performance driven, and the attainment of a set of predetermined results by rural health facilities was a prerequisite to earn subsidies. There were various agents involved in the management of RBF, with Crown Agents as the main fund manager. They described the objective of RBF in improving rural health facilities and the health care delivery system by stating:

“RBF money is given to the clinics according to performance. There should be results based on specific outputs for you to earn subsidies from RBF, if you do not perform, you do not earn.” (CCN)

“Funds earned from RBF are used to upgrade the standards of rural health facilities. This programme has got many funders, however it is managed by Crown Agents.” (RHFN)

Literature that refers to this category indicates that RBF is based on results and the quality of service outputs (Schoffelen et al 2016:30). They posit that results are based on agreed outputs or selected indicators in contractual relationships between the service providers and the CDVA. Basinga (2011:24) concur that RBF pays health facilities based on outputs or results as opposed to inputs. Consequently, the larger the volume of health services rendered, the larger the payment a health facility receives. This is the hallmark of RBF.

#### **b) Category 1.1.2: Focus on maternal and child health**

Data from all participants indicated that RBF was a maternal and child health centric model, particularly focused on under-fives and pregnant mothers. This is evidenced by a high indicator price of \$12 for clinic deliveries that has been maintained since inception of RBF in Zimbabwe. The main goal of RBF was a reduction or improvement of maternal mortality (MMR) and infant mortality (IMR) in Zimbabwe.

The following quotes support the findings:

“RBF focuses on under-fives and pregnant mothers that is why the indicator price for clinic delivery is the highest, pegged at \$12.” (CCN)

“The main goal of RBF in Zimbabwe is to reduce maternal mortality ratio, although we have indicators for other health care services. RBF prioritises maternal and child health care services.” (RHFN)

A study by Ir, Korachais, Chheng, Horemans, Van Damme and Meesen (2015:3) in Cambodia, indicated a similar focus of RBF. This resulted in a decrease in MMR by



more than 50% within a space of 5 years, from 473 to 203 per 100 000 live births. This is regarded as the strength of RBF as well as a subsequent positive outcome of the financing model, particularly in developing states with weaker economies and correspondingly weak public institutions such as health care.

**c) Category 1.1.3: Proper documentation**

Data gathered from participants showed the importance of complete, accurate and proper documentation in the implementation of RBF. Participants described important data elements such as full name, date, physical address, age, sex and diagnosis or the service provided that need to be documented in order to receive full reimbursement. Additionally, they stressed that what is not documented is regarded as not done.

Verbatim statements made by the participants in relation to documentation reflected:

“Writing should be eligible. On a daily basis, we need to capture full data including all six components of RBF that is, full name, full address, age, sex, date and service provided or diagnosis to realise full reimbursement”. (RHFN)

“RBF encourages proper documentation and full data collection to give a true indication to the authorities of what is taking place at the health centre. What is not documented is not done and we will not be paid for it, so we have to document everything.” (CCN)

Proper documentation is an integral part of RBF and indications are that patient documentation has improved owing to the RBF model, as shown by a study conducted in Burkina Fasso by Ye et al (2016:19). Keeping medical records in order provides a point of reference in future even after the nurse has long left thus, giving seamless care beyond individual health care providers.

**d) Category 1.1.4: Client-centred care**

Participants described that RBF has an element of client/community centeredness because it is aligned to the specific health care needs of the rural population. They indicated that the health financing model is designed to address health conditions that predominantly affect the rural population which is usually disadvantaged.

Participants' views were:

“RBF has been designed in such a way that it addresses client needs. It is tailor made to address the health care needs and challenges of the rural population.” (CCN)

“Under RBF, our daily routine at the clinic is to provide health care to the needy and most vulnerable members of the society by increasing access through free health care services.” (RHFN)

Findings are supported by literature which points that the RBF scheme in South Kivu in the Democratic Republic of Congo was patient centred and driven to address vertical equity. Thus, health facilities were reimbursed for expenses incurred in providing free health care services to poor patients (Grittner 2013:23). Vertical equity, particularly in health care has long been standing in developing states and redress through RBF is an important intervention that closes the gap in access to health care between the poor and the affluent.

**4.3.1.2 Subtheme 1.2: RBF as Quality oriented financing model**

According to Schoffelen et al (2016:16), RBF is an instrument for improving health systems, and supporting universal health coverage and the quality of health care in developing nations.

In this subtheme, RBF as quality oriented financing model, three categories emerged: verification levels, reimbursement structure, and indicator-based payment structure.

**a) Category 1.2.1: Verification levels**

Participants from both rural and council clinics acknowledged the importance of first and second level verification. The relationship between verification and quality was acknowledged, however, a few participants viewed first level verification and second level verification as a duplication. There were variations in verification approaches in RHF's and council clinics. These were related to the duration and frequency of the verification process.

The majority of participants viewed second level verification as an empowering process as it involved mentoring and recommendations for improvements. They were encouraged to use the Zimbabwe Expanded Programme on Immunisation registers.

This is indicated in the quotations from the participants:

“First level verification helps us do corrections before the second verification. The first stage is usually done by a senior nurse to improve our work. Without it I don't think quality of health care will be at the levels that we are experiencing at the moment. Verifiers come on a monthly basis at our health facility, it takes about 45 minutes.” (CCN)

“Verification is key for quality of care at facilities implementing RBF, but I think it's more of duplication of duties because what has been verified at first level verification is the same as second level, because they will be looking at the same documents. Verifiers come once every quarter at our health facility.” (RHFN)

“First level verification takes very long at our facilities, between 2-3 hours and it is done on a quarterly basis by the sister in charge. She usually comes to review our clinic registers for quality of documentation, checking completeness and the 6 components of RBF.” (RHFN)

“Second level verification is done by Crown Agents, They identify areas we need to improve on and provide recommendations to solve

challenges. They encourage us to use registers such as the Zimbabwe Expanded Programme on Immunisation registers.” (CCN)

Gunda et al (2013:38) agree that as a way of preserving programme integrity and ensuring quality assurance, rural health facilities implementing RBF are subjected to a dual meticulous verification process. These are conducted internally by the sister in charge and the community nurse, and externally by the CDVA.

Verification provides the opportunity to monitor quantity and quality of services, including patients’ satisfaction, so that remedial action can be timeously instituted (Antony, Bertone & Barthes 2017:20).

#### **b)      Category 1.2.2: Reimbursement structure**

All participants described the reimbursement structure in terms of quantity and quality. Quantity verification uses various indicators, and is done by the independent CDVA. It generates 80% of the total earnings for a health facility. Quality is done by the District Health Executive. It constitutes 20% of total earnings and uses clinical and structural indicators. The distribution of incentives is according to seniority and a considerable percentage is allocated to the improvement of clinic infrastructures.

Participants relayed:

“Our payment is based on quantity indicators done by the second level verifier, they review our clinic registers and ANC 4+, delivery, TT2+, PNC among others. Quantity earnings constitute 80% of the total health facilities’ earnings.” (RHFN)

“The DHE is a team of medical, nursing and administrative professionals, they visit our clinics and use a quality checklist to check the quality of our services. Quality scores bring in 20 % of our earnings. 25% of the total earnings of a facility goes to staff incentives and the remaining 75% is for the development of the health facility.” (CCN)

“The administrator uses an incentive calculator to share incentives among staff. The more senior you are the more you get because of increased duties and responsibilities, if you are junior, you get less.”

(RHFN)

**c) Category 1.2.3: Indicator-based payment structure**

An indicator is a measurement, which shows the degree of achievement or level of fulfilment of an objective or target (Schoffelen et al 2016:120).

Most participants mentioned that indicators such as antenatal care (ANC) bookings, postnatal care visits, immunisations and delivery are used to measure performance, and is rewarded accordingly. They explained how the indicators work and provided examples from their own experiences.

The following verbatim quotes support the findings:

“Money is earned through indicators such as ANC bookings, deliveries, postnatal care visits, immunisations, the checklists and others. If pregnant mothers book early, before 16 weeks, I get money from RBF. If they attend ANC 4+ again it is an advantage to me, I get more money.”

(RHFN)

“Delivering at health facilities will ensure that the clinic gets money from RBF. It is a game of numbers, if I get 10 out of 10 from those indicators, it’s a success, we get paid more.” (CCN)

These findings are similar to those of a study conducted by Rudasingwa and Uwizeye (2017:8) on physicians' and nurses' attitudes towards PBF incentives in Burundi. They found that RBF rewards were tied to quantity indicators, which were evaluated and paid monthly, and quality indicators were evaluated and paid quarterly. Attaching performance to incentives positively impacts performance of health care, ultimately strengthening health care delivery systems.

#### **4.3.2 Theme 2: Role of nurses in the implementation of RBF**

Nurses described their roles in the implementation of RBF and two subthemes emerged, namely: current clinical practices, and administrative functions.

The subthemes and categories are presented in Table 4.3.

**Table 4.3: Role of nurses in the implementation of RBF**

<b>Theme</b>	<b>Subtheme</b>	<b>Category</b>
<b>Theme 2: Role of nurses in the implementation of RBF</b>	Current clinic practices	<ul style="list-style-type: none"> <li>• Perceived significance of role within the team</li> <li>• Delivery of basic care services</li> </ul>
	Administrative functions	<ul style="list-style-type: none"> <li>• Role in procurement processes</li> <li>• Planning of care and governance</li> <li>• Community participation in RBF implementation</li> </ul>

##### **4.3.2.1 Subtheme 2.1: Current clinical practices**

Participants regarded teamwork and collaboration as important in the success of RBF. Two categories emerged from the data, namely perceived significance of their role within the team, and delivery of basic care services.

##### **a) Category 2.1.1: Perceived significance of role within the team**

Participants used metaphors to describe their interdependent roles in the implementation of the RBF model. They perceived their clinical functions as very important and likened their roles to sport positions. Male participants used metaphors such as striker, midfielder and defender, whereas female participants used metaphors such as shooter, centre and goal keeper.

The following verbatim quotes illustrate the findings:

“As a striker, you have to score goals for your team to win. In RBF, I would consider myself a striker, because in RBF, you have to aim for high standards, you have to score more points so to earn higher subsidies.” (RHFN)

“A centre has to run around, I am working with pregnant mothers and babies and strikers depend on me in the centre to get the ball equally distributed. I see myself as a midpoint between community and health care professionals, because I promote clinic deliveries.” (RHFN)

“I am also the centre because the ball starts at the centre. So, as a nurse I am the one who is going to start with the patient until to the point where I will release the patient to the skipper to score. For RBF to be successful, I have to be the pivot of the whole programme.” (CCN)

“I would consider myself a striker, because in RBF we want results and these results must be attainable, so as a striker you are there to score goals and as a shooter you are there to shoot, so all other people depend on me to produce results. We are results oriented.” (RHFN)

**b) Category 2.1.2: Delivery of basic care services**

All participants described their current practice as a holistic approach that integrates patient care, diagnosis, health education, documentation and promotion of service utilisation through social marketing. They also collaborate with village health care workers to encourage pregnant mothers to book early and deliver their babies at health facilities.

This is indicated in the following quotes from the participants:

“As a nurse, my role includes comprehensive patient care, health education, proper documentation as well as promoting the use of health care services in the community. I offer my nursing expertise by providing quality care as well as social marketing of health care services and RBF.”  
(RHFN)

“We work with village health workers and they are also involved in encouraging pregnant mothers to book early and deliver at health facilities as it is important for RBF”. (CCN)

Goetz, Marx, Marx, Brodowski, Nafula, Prytherch, Awour and Szecsenyi (2015:1) agree that the roles played by health care professionals are fundamental to the success of health care delivery systems.

#### **4.3.2.2 Subtheme 2.2: Administrative functions**

Participants described their administrative functions associated with RBF. Three categories emerged, namely procurement processes, planning of care and governance, and community participation in RBF implementation.

##### **a) Category 2.3.1: Role in procurement processes**

Participants described their responsibilities regarding the procurement processes. Their main role seemed to be in planning and setting up meetings with community health centre committees (CHCC), as well as obtaining various quotations, ordering and making payments. One member of CHCC is a signatory to the health facility's bank account. The procedures were similar in both types of health facilities.

Participants stated:



“We call for meetings with the health centre committees to decide on what to buy for our health facilities, upon agreement we then source quotations. We also come up with comparative schedules for the sourced quotations.” (CCN)

The Robert Wood Johnson Foundation (2015:3) postulates that modern day nurses are well positioned to help meet the evolving needs of the health care system. They play various vital roles, including purchasing supplies and commodities for health facilities, thus delivering seamless, coordinated and responsive care to communities.

**b) Category 2.3.2: Planning of care and governance**

All participants expressed views that indicated they are now enabled to plan and govern their health care facilities effectively, using operational plans. They indicated that operational plans ensured financial discipline, and adherence to the plan was key to full reimbursement and continuity of health facilities.

Participants said:

“We now write operational plans, you have to map the way you want to go and how to do your work. It is important because our output is linked to the payments” (RHFN)

“In order to get full reimbursement and to remain on the RBF programme, health facilities must adhere to operational plans. We need to be disciplined in everything we do and document.” (CCN)

In their study, Mukuna, Mwaura-Tenambergern and Adoyo (2015:9) found that nurses play important roles in health care, such as decision making for health care, planning and resource mobilisation for an efficient health care delivery system. Nakhimovsky, Langenbrunner, White, Vogus, Zelelew and Avila (2014:11) agrees that holistic and multi-tasking nurses are better equipped to implement health care systems strengthening through effective planning.

**c) Category 2.3.3: Community participation in RBF implementation**

Community participation in health service delivery was described as important. Participants indicated that the creation of the Health Centre Committees was a prerequisite to enrolment in RBF programme.

The committee plays a crucial role in the initiation of support groups responsible for facilitating outreach programmes, following up with patients, and procurement processes.

These participant quotes support the findings:

“Formation of health centre committees was a requirement from RBF, so as to entrench transparency in whatever we are doing. HCC are signatories to all procurement processes.” (CCN)

“The committee assists us with formation of health support groups and the mobilisation of the community for outreach programmes and follow up on patients in the community.” (RHFN)

Wilhem, Brenner, Muula and Allegri (2016:16) assessed the acceptability and adoption of RBF in Malawi. Their study revealed the importance of early involvement of all stakeholders at all levels during the implementation of the RBF process. Community participation is regarded as one of the cornerstones in health systems strengthening. In donor funded programmes, community participates in various processes that contribute to programme sustainability (United States for International Development (USAID) 2015:4).

### 4.3.3 Theme 3: Evaluation of RBF

Two subthemes emerged from Theme 3, namely perceived successes, and challenges in the implementation of RBF. The subthemes and categories in Theme 3 are presented in Table 4.4.

**Table 4.4: Theme 3: Evaluation of RBF**

Theme	Subtheme	Category
<b>Theme 3: Evaluation of RBF</b>	Perceived successes	<ul style="list-style-type: none"><li>• Incentives, staff motivation and confidence</li><li>• Improved health outcomes (increased access, reduced MMR, IMR)</li><li>• Improved client satisfaction and increased accountability</li></ul>
	Challenges in the implementation of RBF	<ul style="list-style-type: none"><li>• Tedious procurement processes</li><li>• Impact of cultural beliefs and low catchment population on reimbursements</li><li>• Lack of continuum of care</li><li>• Staff shortage and workload</li><li>• Uncertainty over sustainability</li><li>• Rigid financial structure</li></ul>

#### 4.3.3.1 Subtheme 3.1: Perceived successes

In this subtheme, participants described various successes related to RBF. Three categories emerged from the subtheme, namely incentives, staff motivation and confidence, improved health outcomes (increased access, reduced MMR, IMR), and improved client satisfaction and increased accountability.

##### a) Category 3.1.1: Incentives, staff motivation and confidence

Data from all participants revealed that incentives paid to them by RBF were a source of motivation. They highlighted that through training, they gained substantial

knowledge regarding financing of health care, and they felt empowered and more confident.

The following statements support the findings:

“With RBF funds, we are now able to buy and stock drugs. In emergencies, patients are transferred to the district hospital using petty cash. You get this sense of fulfilment when you have the resources.”  
(RHFN)

“Comparatively, health facilities funded by RBF are better off in terms of quality of health services, medical equipment and general appearance.”  
(CCN)

“Incentives from RBF is a motivation for us to work hard and stay far in remote areas. The knowledge gained from managing finances empowers us, we feel more confident.” (RHFN)

McCunes (2014:2) agrees and says that financial compensation and the potential to receive such payments in recognition of hard work positively impacts on health provider motivation. Health care workers derive motivation both intrinsically through increased confidence and extrinsically through incentives paid to them as a reward for their efforts.

**b) Category 3.1.2: Improved health outcomes (increased access and reduced MMR and IMR)**

Data suggested that the free approach captured in the RBF model provided patients with free access to health care at RHF. The majority of participants believed that many lives have been saved and morbidity rates have improved. RBF reduced the cost of transport and health care, which resulted in reduced MMR and IMR.

Participants revealed:

“We used to have a lot of complications when mothers delivered at home. With the RBF program, complications are identified early and attended to on time. The nurse is able to manage the patient at the primary health care facility and if need be, refer them.” (RHFN)

“Previously, some patients died at home due to the required prohibitive user fees, but that has improved because of RBF. MMR has dropped to below 300 from 600 per 100 000 in 2011, IMR, dropped from 132 to below 100 per 1000.” (CCN)

One of the broad objectives for the adoption of RBF was to reverse the escalating MMR in Zimbabwe to a single digit by 2020 (MoHCC 2017:18). Brenner et al (2014:6) posit that RBF initiatives seek to improve the quality of maternal and neonatal health care (MNHC) delivery and utilisation in public health facilities. Reduction in MMR is a key indicator associated with the RBF model and is a case in point of evaluating the improvements in health care access and utilisation.

**c) Category 3.1.3: Improved client satisfaction**

Client experience is one of the indicators of good service. Participants explained that patients and the community expressed satisfaction with the availability of health infrastructure, resources and services. The increase in the number of patients was also viewed as an indication of client satisfaction.

Supporting statements reflect:

“Patients and the community are happy that they now receive medication at their local clinic and no longer spend on transport to the district hospital for medication.” (CCN)

“With RBF, we now have a waiting mothers’ home and provide food for them. Both clients and the community have acknowledged the support with food and accommodation.” (RHFN)

Client satisfaction is important in monitoring and evaluation. It can be measured using waiting times, staff attitudes, and the cleanliness of a health facility. This evaluation takes place quarterly, and is conducted by the selected community based organisations or the Ministry of Social Services (MoHCC 2017:51).

Findings by Van de Looiji, Mureyi, Sisimayi, Koot, Manangazira and Musuka (2015:9-10) also reflect an increase in client satisfaction in districts that were implementing RBF in rural Zimbabwe.

#### **4.3.3.2 Subtheme 3.2: Challenges in the implementation of RBF**

Six categories emerged from the subtheme, namely tedious procurement process, impact of cultural beliefs and low catchment population on reimbursements, lack of continuum of care, staff shortage and workload, uncertainty over sustainability, and financial structure.

##### **a) Category 3.2.1: Tedious procurement process**

Data from participants offered various indications that procurement red tape was a challenge to the successful implementation of RBF. They claimed that the bureaucratic processes involved diverted time and attention away from patients. They also cited lack of suppliers in the Murewa district, and lack of clarity on approved supplier lists.

Participants said:

“For procurement, we go through all the required paper work, we spend time travelling from the clinic to Murewa district office for approval. We also spend time travelling to Harare to source quotations, as there are

no reputable shops in Murewa. During these periods the health facility is closed and patients are deprived of health care services.” (RHFN)

“It takes two or more meetings with the Health Centre Committee for procurement to be finalised, if you don’t use the approved supplier, your request is rejected and you have to restart the process.” (CCN)

Kaufmann and Tummers (2016:3) assert that bureaucratic processes hinder operational efficiency and quality of service for the organisation and clients. Red tape introduces inefficiencies in systems and presents not only delays in decision making and execution, but also breeds fertile ground for corruption in an attempt to hasten processes by various players involved.

**b) Category 3.2.2: Impact of cultural beliefs and low catchment population on reimbursements**

Low catchment population refers to facilities that serve a community of not more than 5000 people (MoHCC 2017:36). Participants cited cultural beliefs and low catchment population as negatively impacting on reimbursements to RHF. This was in reference to ANC booking before 16 weeks, which is not adhered to by some patients. Health facilities serving low catchment populations were disadvantaged both in subsidies earned and staff incentives. They had low earnings due to low patient volumes, irrespective of the high-quality service they delivered.

The following statements support these findings:

“The challenge of RBF is the emphasis of early ANC booking. We put all the effort and all the knowledge we have to improve on that indicator, but at the end of the day we still find many of these women reporting after 16 weeks gestational age. In their culture, they are not supposed to disclose pregnancy before quickening” (RHFN)

“RBF is a game of numbers, the more patients you attend to, the more subsidies you earn. We are disadvantaged because of serving a low

catchment population. Therefore, at the end of the quarter, we earn low subsidies.” (CCN)

Chimhutu, Lindsvik and Lange (2014:11) posit that in order to reach P4P targets, many health facilities in the district developed negative strategies to attract and or force clients to utilise their services. Such practitioners used threats such as a penalty or a fine if expectant women delivered at home, and they would be denied a live birth card and or vaccination for their new-born baby.

**c) Category 3.2.3: Lack of continuum of care**

Data from all participants showed concern over lack of continuity of healthcare. Patients referred from RHF to the district hospital for further assistance need to pay, and thus fail to access free health care. District hospitals charge user fees because they are not on RBF. Participants believed that lack of access to care at secondary care level facilities reverses the health outcome gains at primary health care level.

The following verbatim quotes support the findings:

“The exclusion of district hospitals in the RBF program has been a problem. Patients are made to pay for services, this is problematic.”  
(CCN)

“Patients with complications need special attention; they may choose to deliver at home because of lack of money. It is discouraging because all the effort we put into primary care is wasted, and this will increase death rates.” (RHFN)

RBF is a health financing model designed to advance the goals of Primary Health Care by enhancing access to care, bringing it nearer to where the community lives, works and learns, all the way to quaternary levels following the continuum of care as necessary (MoHCC 2017:19).



**d) Category 3.2.4: Staff shortage and work load**

Participants cited staff shortage as a challenge, particularly at health facilities that do not have an Environmental Health Technician. Staff compliment could be as low as one nurse per rural health facility, making it difficult to cope with both clinical and administrative duties. A few mentioned that attendance of workshops, meetings and weekends impacted their income negatively, since they had to close the health facility during their absence. Participants concurred that workload at RBF facilities had increased due to increasing numbers of patients from other areas.

The following quotes support this finding:

“Due to staff shortage, mistakes are most likely to happen and without Environmental Health Technician [EHT] we lose money. Some patients outside our catchment population come to our facility because we don’t charge user fees, and that increases work load.” (CCN)

“Because I work alone, my clinic is closed when I attend meetings and workshops and this makes me lose money and also affects patients.”  
(RHFN)

Rudasingwa and Uwizeye (2017:18) also found that the majority of the nurses had to cope with high patient numbers due to RBF. However, McCunes (2014:2) noted that increased workload actually act as a motivator as it brings higher income from RBF, but however causes burn-out.

**e) Category 3.2.5: Uncertainty over sustainability**

All participants verbalised concerns over the sustainability of RBF. They were not aware of the duration of the funding and were uncertain about the continuity of some positive outcomes from RBF in Zimbabwe. They did not have information about the support they would receive once the financing is withdrawn.

Participants said:

“We are not sure how long RBF will take, like other donor funded programs, its time expires then everything collapses.” (CCN)

“No one knows the government plan for taking over and continue with the programme when donor support is withdrawn.” (RHFN)

In Wilhem et al's (2016:20) Malawian study, findings show that every Malawian stakeholder was also concerned with what would happen once external funders stopped supporting the RBF intervention. There were many uncertainties about the future once donor support is withdrawn.

**f) Category 3.2.6: Rigid financial structure**

Data from participants showed concerns over delays in subsidy disbursement and access to the funds once deposited in their bank accounts, due to cash shortages currently prevailing in the nation. They also raised concerns over low indicator prices and indicator price discrepancy, limited financial autonomy, and reimbursement criteria. The health facilities did not have the autonomy to hire temporal staff using RBF funds.

The following statements support the findings:

“RBF funds take too long to be paid to our health facility account. Even when the money is in my account, it takes a long time to access it because cash is not readily available at the banks. We have limited financial autonomy, because RBF prescribes what we should or not do with subsidies. We do not have authority to employ temporary staff.” (RHFN)

“Our OPD indicator price is too low compared to those managed by Cordaid. Here OPD indicator price is \$0.10 and theirs is \$0.50. For this reason, their health facilities are better developed and managed.” (CCN)

Literature reports that there were complaints raised for late and incomplete distribution of payments. There are challenges with indicator prices, and the financial premiums were labelled as weak by participants implementing RBF (WHO 2013:20; Paul et al 2014:8-9). However Van de Looij et al (2015:10) reported that health facilities had some measure of financial autonomy such as hiring temporal staff using RBF funds. In Benin, Paul et al (2014:8) reported the perceived unfairness of RBF towards operational staff. Health care providers felt the discrepancies in reimbursement structure were not fair.

#### 4.3.4 Theme 4: Strengthening implementation of RBF

Two subthemes emerged from Theme 4: improving the organisation of RBF, and reducing bureaucracy in operations. The subtheme and categories of Theme 4 are presented in Table 4.5.

**Table 4.5: Theme 4: Strengthening implementation of RBF**

Theme	Subtheme	Category
<b>Theme 4: Strengthening implementation of RBF</b>	Improving the organisation of RBF	<ul style="list-style-type: none"> <li>• Review of reimbursement and payment criteria</li> <li>• Attention to staff compliment</li> <li>• Measures for sustainability &amp; continuity</li> </ul>
	Reducing bureaucracy in operations	<ul style="list-style-type: none"> <li>• Reviewing procurement procedures</li> <li>• Increase financial autonomy</li> </ul>

##### 4.3.4.1 Subtheme 4.1: Improving the organisation of RBF

Participants offered recommendations to strengthen the implementation of RBF. Three categories emerged from the subtheme, namely, reviewing of reimbursement and payment criteria, attention to staff compliment, and measures for sustainability and continuity.

**a) Category 4.1.1: Review reimbursement and payment criteria**

Several recommendations were made. Participants indicated that the indicator price should be reviewed and the payment criteria should incorporate cultural beliefs practiced by communities. They also recommended uniformity of indicator prices across RBF programmes currently running in Zimbabwe.

Participants suggested timeous disbursements of funds to low catchment population health facilities.

This is to support low volume sites to adequately meet their health facilities' financial needs; a suggestion of \$500 per quarter was made. There were recommendations that district hospitals should also be included on RBF to provide continuity of care from primary health care through secondary levels of care.

The following verbatim quotes support the findings:

“The 10 cents should be increased to between 20 and 50 cents for OPD services. Indicator prices should be uniform among the two RBF programmes managed by different fund holders.” (CCN)

“RBF should consider paying all ANC bookings done at rural facilities irrespective of the booking times. Cultural beliefs must be considered.” (RHFN)

“I recommend that turnaround time of subsidy payments should improve to sustain operations at our health facilities. These payments should be done monthly as opposed to the current quarterly arrangement.” (RHFN)

“Health facilities with low populations should have extra funding to augment their low earnings. Village health workers also deserve remuneration for the effort they put into the program.” (CCN)

“I think a new and well informed method of payments need to be investigated to satisfy personnel at all levels of population catchment areas.” (CCN)

“RBF funds should be extended to include district hospitals, this will make it possible for patients to access further health care when needed.”

(RHFN)

Ir et al (2015:18) indicated that in Cambodia, inclusive incentives improved referrals of pregnant women from villages to health centres for delivery. Incentives were given to both traditional birth attendants and community health workers. Schoffelen et al (2016:40) argue that certain areas need to be compensated with additional bonuses on top of the basic subsidy for the indicators. Wilhem et al (2016:16) agree that involving stakeholders at administrative, local, district, and national levels in the early stages of RBF roll-out is important for successful implementation.

**b) Category 4.1.2: Attention to staff compliment**

Participants strongly recommended that low volume serving health facilities should also have technical, junior administrative and support staff as a way of addressing staff shortage and high workload. They expressed an urgent need to adequately address the challenge of staffing.

Participants explained:

“All low volume sites should be equally treated by providing them with the necessary resources and infrastructure to alleviate problems at the facility.” (RHFN)

“I suggest that RBF should allow us to employ junior and admin staff to assist in the administration, procurement departments and during verification visits.” (CCN)

Rudasingwa and Uwizeye (2017:18) agree that staff improvements are necessary for nurses to cope with the increasing work load that is associated with RBF free care services, and the administrative requirements. Adequate staffing is key in addressing

burn out and alleviating overworking for health care staff, considering the increased workload associated with RBF.

**c) Category 4.1.3: Measures to ensure sustainability and continuity**

Participants recommended that the RBF should not solely rely on donor funding as it poses a risk of programme collapse once funding is withdrawn.

The government should explore ways of mobilising resources for the RBF programme to ensure sustainability. They recommended the continuation of the RBF model and that it should not be a short-term contract, but a long-term commitment.

The following verbatim quotes support the findings:

“To sustain the RBF program, there must be a plan in place to continue with it when donors choose to pull out at any given point in time, so that the gains realised in Zimbabwe’s health care delivery system during this RBF era are sustained and consolidated into the future.” (RHFN)

“Government should look at innovative health financing models that draw financial support from domestic resources to ensure RBF continuity.” (CCN)

Ye et al (2016:16) agree that RBF programmes should be funded through local resources as opposed to the traditional donor dependence approach. Local resource mobilisation and funding is a critical element that speaks to sustainability and ownership of structural and institutional reforms for developing states, which usually comprise weak institutions.

**4.3.4.2 Subtheme 4.2: Reducing bureaucracy in operations**

Two categories emerged, namely reviewing procurement procedures, and increasing financial autonomy.

**a) Category 4.2.1: Reviewing procurement procedures**

Participants recommended that procurement should be done by DHEs or approved suppliers in Murewa district should be identified to eliminate the lengthy procurement processes. Some participants recommended that the approach used by schools (where procurement is done by the education committee, leaving teachers to focus on teaching), could be adopted. Others advocated for RBF representative to visit rural facilities for procurement approval. A few suggested that quotations should be eliminated for minor equipment. In addition, there must be specific dates for reviewing the requests for payments.

The following quotations represent the views expressed:

“For procurement, we should do like what is done in schools, where procurement processes are handled by the committee only, thus, giving the nurse good chance to focus on clinical aspects.” (RHFN)

“RBF representatives should be sent to the clinic to discuss and advise on all purchases, quotation of small items like BP machines should be removed. Also, they must set specific dates for people to come with their purchase order form for approval.” (CCN)

**b) Category 4.2.2: Increasing financial autonomy**

Although participants reported some form of autonomy in planning for health care facilities, they believed that they should be allowed to exercise greater financial autonomy. They said:

“At my clinic, there is no nurse aid or general hand and I am assisted by village workers. Therefore, RBF funds should allow us to give them something. That will be a decent way of working with volunteers.” (CCN)

“I think we will be more effective if we are empowered to make financial decisions that allow us to improve the quality of services.” (RHFN)

Findings from a study conducted by Van de Looij et al (2015:10) indicated that some health facilities implementing RBF enjoyed some degree of financial autonomy in hiring temporal staff using RBF funds. As such, it may in a way suggest the possibility of incorporating elements of financial autonomy, locally.

#### **4.4 EMERGING RELEVANT OUTLIERS**

Some comments raised only once were also important to this study. The comments were on the question: “Tell me your views about the RBF model?”

##### *Quotation 1: Legacy debt*

Participants from council clinics raised concerns over enduring historical debt left behind by local authorities, particularly at council owned clinics. They recommended some form of flexibility to service legacy debt left behind by local authorities.

“I recommend that RBF should allow us to pay longstanding bills such as electricity bills using RBF funds, this will go a long way in alleviating the legacy debt we inherited from council.” (CCN)

“To give us a fresh start, RBF should assist us with a package that will put closure to the challenge of historical debts” (CCN)

#### **4.5 CONCLUSION**

This chapter presented the themes from data concerning nurses’ views and experiences, such as: interpretation of RBF, the role of nurses in the implementation of RBF, evaluation of RBF, and strengthening implementation of RBF. The themes, subthemes and categories that emerged from the participant quotes were presented to describe nurses’ views and experiences regarding implementation of RBF in Zimbabwe. Literature was used to support and elaborate on the findings.



Chapter 5 presents conclusions and recommendations of the research study.

## **CHAPTER 5**

### **INTERPRETATIONS, DISCUSSION OF RESEARCH FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS**

#### **5.1 INTRODUCTION**

This chapter presents the interpretation and discussion of findings emanating from Chapter 4. Themes generated during the analysis are used to provide an in-depth interpretation. The chapter furthermore acknowledges the limitations and draw conclusions. Recommendations on how to strengthen the implementation of RBF are provided.

#### **5.2 RESEARCH METHOD AND DESIGN**

The researcher employed a qualitative, explorative descriptive design to explore nurses' views and experiences regarding implementation of RBF in Zimbabwe.

The following research questions guided the study:

- What are the nurses' views regarding RBF in Zimbabwe?
- How do nurses experience the implementation of RBF in Zimbabwe?

Based on the presentation of findings and discussion in relation to literature in Chapter 4, it is evident that some adjustments and modifications in the structure and implementation of RBF in Zimbabwe are required. The views and experiences of nurses are important for improving the effectiveness of the financing model.

#### **5.3 FINDINGS AND CONCLUSIONS**

Summaries are discussed under different themes generated from data. Four major themes emerged.

The first three themes are related to the views and experiences of nurses regarding RBF implementation in Zimbabwe. The fourth theme presents their recommendations on how to strengthen RBF in Zimbabwe.

### **5.3.1 Theme 1: Interpretation of RBF**

Nurses had the opportunity to express their understanding of RBF. They subjectively shared their views and experiences of implementing the RBF model at rural health facilities. Valuable data, with potential to guide and inform policy and decision makers, emerged.

#### **5.3.1.1 Subtheme 1.1: Meaning of RBF**

Participants used different phrases to describe RBF, however, their interpretations were largely consistent with theoretical definitions in literature as presented in Chapter 2. Some nurses perceived RBF as a model that rewards good performance, whereas others construed RBF to be a financing model that links payments to results. Makoni et al (2014:3) agree about the links between RBF and measurable results. It is evident that RBF puts emphasis on outputs; it pays for results. This point came up strongly in their descriptions of RBF. The apparent benefit would be increased outputs and subsequent benefits to patients.

Nurses indicated that RBF's primary focus was maternal and child health care, as evidenced by ANC indicators, which are designed to encourage early delivery bookings and clinic deliveries. Ye et al (2016:2) confirmed that in Burkina Faso, RBF aimed to improve the health of mothers and children. They used the Community Health Centre Committees (CHCC) to motivate rural women to register their pregnancy before 16 weeks and deliver at the clinics. These were positive strategies. However, it seemed that they were driven with an emphasis on outputs.

Data showed that proper documentation was essential for this health financing model. The assumption is that, if the focus is on outcomes/outputs, there must be evidence that work was done.

In health care delivery, quality documentation requires a well-designed health information management system; clinicians need to know what needs to be recorded, how and when. Complete documentation enables effective communication between care givers and authorities, and it facilitates good performance evaluation (Rudasingwa & Uwizeye 2017:15). Therefore, they ensured that all required data elements, such as the date, and patients' age, name, surname, weight, BP and homestead were documented for the health facilities to get full reimbursement. Additionally, nurses believed that RBF was client-centred, in that basic needs such as accommodation facilities for pregnant mothers and meals were catered for, thus making health care accessible. Their interpretation was consistent with the directives of the MoHCC, that health care delivery systems should be responsive to the health care needs of patients (MoHCC 2017:14).

#### **5.3.1.2 Subtheme 1.2: Quality oriented model**

RBF was viewed as a quality oriented model whose integrity was assessed through verification processes that are conducted both internally and externally. Similarly, Paul et al's (2014:7) study in Rwanda found that health practitioners believed that verification strengthens practice capacity and builds management, as it enables onsite training. Participants understood verification as a process that encouraged quality service outputs. Verification was a two-dimensional process with 20% focused on quality and 80% on quantity. However, some participants had reservations about second level verification; they claimed it was an unnecessary duplication. Normally, the senior professional nurse conducts the first level verification and the second level, which includes capacity building, is conducted externally by the Contract Development and Verification Agency (CDVA) to validate financial and data accuracy (Gunda et al 2013:38). This monitoring and evaluation process has the potential to reinforce efforts to improve quality of care.

There were variations in the verification processes between council clinics and rural health facilities in terms of frequency and duration. In council clinics, the duration of the process was 45 minutes to 1 hour, and it took place monthly. In the rural health facilities, the process lasted 2 to 3 hours and was conducted quarterly. However, the verification steps were similar in all facilities.

It is evident that RBF puts emphasis on outputs, it pays for results and the success of the programme depends on monitoring and verifying results. Nurses needed to increase their efforts in areas where they would receive incentives/payment. Subsidies earned were split between personnel at 30% and facility development at 70%. These subsidies were seen as motivation and were considered fair. At the same time, they recognised that it was not a perfect system. The participants believed that the continuation of staff motivation would promote the achievement of goals. They were incentivised to implement basic care services, including the immunisation programme.

Since the focus of RBF is on maternal and child health care, the majority of nurses mentioned that the health care financing model used selected national indicators to measure performance and calculate reimbursements. Therefore, a higher percentage of incentives came through clinic deliveries; there was no reimbursement for home deliveries. The RBF programmes in Malawi and Burundi are also measured by quantity and quality indicators (Rudasingwa & Uwizeye 2017:9).

### **5.3.2 Theme 2: Role of nurses in the implementation of RBF**

This section focuses on how nurses experienced the implementation of RBF in their health facilities.

#### **5.3.2.1 Subtheme 2.1: Current clinical practices**

Participants perceived their roles as significant for the sustainability of RBF in Zimbabwe. They viewed themselves as key players in health care provision and in collaborating with communities through the RBF model. They used metaphors to highlight their role in the implementation of RBF. The majority of nurses in the rural facilities perceived themselves as shooters and strikers, as in a soccer match. Those in council clinics likened themselves to the centres and midfielders. Such strong views suggested that they believed they were integral strands between the community and the health care system. This perception related well to their understanding of the RBF as being client-centred, as described earlier.

Generally, nurses are well positioned to strengthen primary health care services and deliver responsive care to the community.

Their main roles included patient care, health education, and meticulous record keeping. They also recognised the role of village health workers in mobilising the community to utilise health care services such as early bookings for ANC as described in the previous section.

#### **5.3.2.2 Subtheme 2.2: Administrative functions**

Although nurses recognised their important role in the implementation of RBF, they also acknowledged other stakeholders such as the District Health Executive (DHE) and the community as represented by CHCC. Their main administrative role was in health care planning and procurement. Procurement guidelines are rules that govern expenditure of RBF funds at health facilities to enhance transparency (MoHCC 2017:17). Nurses, in collaboration with the CHCC, were responsible for governance and organisation of health care using management tools such as operational plans. Adherence to the plans to realise optimal RBF reimbursements was considered vital for continuity of donor funding. In light of these findings, it was inferred that nurses were executing managerial and administrative functions, over and above their clinical responsibilities.

Also, the study assumed that in an environment where the focus is on outcomes, it is understandable that there would be emphasis on effective planning and quality documentation.

Participants mentioned that it was a prerequisite to form CHCCs, and to ensure transparency as the CHCC members were signatories to health care facilities' bank accounts. They had an important role in planning and procurement processes, as well as health care services extension. The study recognised the importance of synergies between the community and nurses in health systems strengthening.

### **5.3.3 Theme 3: Evaluation of RBF**

The evaluation of RBF implementation generated two subthemes, namely perceived successes and challenges in Zimbabwe.

#### **5.3.3.1 Subtheme 3.1: Perceived successes**

Nurses expressed increased motivation, knowledge, empowerment and confidence following staff incentives gained through RBF. All nurses recognised the improvements in their health facilities compared to non-RBF affiliated facilities. The general appearance, quality of care and resources thrust them ahead of others. They indicated that this was another source of motivation. The study assumed that results based contexts demand measurable outcomes, which motivate nurses to perform at their optimum.

Nurses showed appreciation for the funds provided by RBF to procure essential drugs and medicines, and facilitate referrals; thus, enabling them to deliver quality health care. They were encouraged to remain in their posts in remote areas. Mcunes (2014:2) posit that in Samburu, incentives and performance bonuses from RBF motivated health workers to work in remote areas and reduced staff turnover. Nurses felt empowered as they fully participated in the management of the resources, albeit with some reservations.

Participants described tangible deliverables such as a reduction in MMR and IMR due to abolishment of user fees and improved access to health care. In addition, they believed that clients were generally satisfied with the care provided. The availability of health infrastructure, medicines, reduced travelling costs, accommodation, meals for expecting pregnant mothers and the increasing number of patients seeking care at their health facilities, were considered indicators of improved service delivery and increased client satisfaction. Mcunes (2014: 2) agrees that increased numbers of patients presenting at health facilities may be a confirmation that nurses are doing work that the community values and appreciates. This study recognised that patient satisfaction with care is a quality indicator.

### **5.3.3.2 Subtheme 3.2: Challenges in the implementation of RBF**

The majority of nurses admitted that as much as there were some successes following the implementation of RBF, the challenges were numerous and seemed to reverse the achievements. They admitted that procurement processes were tedious, and indicated that sourcing of quotations were time consuming and in some instances not necessary, as in the case of procuring small commodities. At times, they had to close health facilities and turn away patients to obtain quotations. They believed that this resulted in missed opportunities for both the patients and the health facilities. Patients are denied access and health facilities fail to reach their targets in terms of subsidised outputs, since quantities are significant for an output driven system.

Nurses experienced the negative impact of cultural practices and low catchment population on reimbursements. As mentioned previously, the local belief system prevented women from early ANC registration, ultimately affecting the earnings from RBF. The low catchment areas also affected the subsidies; they earned less, irrespective of the quality care provided. In addition, the exclusion of district hospitals from RBF created a breakdown in the continuum of care. Patients referred from primary health care facilities to district hospitals were not able to access health care services due to user fees. Participants described this discontinuation of service as a reversal of positive health outcomes achieved at the primary care level.

The other challenges nurses experienced were the increased workload and shortage of staff. This resulted in long working hours and a subsequent increase in the probability of human error, fatigue and burn-out. Mccunes (2014:2) and Rudasingwa and Uwizeye (2017:18) confirm that RBF already operates in areas with low human resources and the associated administrative workload poses a serious challenge to staff morale. These concerns seemed to create tension between the need for higher incentives, calculated on quantity of outputs, and the realities of human capabilities. Some participants in council clinics believed that the criterion 'presence of an Environmental Health Technician at health facilities' was not reasonable, as issues of staffing were not under their control. They scored zero on that indicator.



There were also challenges with delayed payments to health facilities, which had detrimental effects on health facility operations. Mcunes (2014: 3) has also found similar delays in Kenya. Brenner et al (2014: 7) confirm that the subsidy turnaround time for the RBF programme in Malawi was six months. They identified many challenges caused by the delay. In general, nurses appeared content with the incentives that improved their personal lives and the working environment. However, some council clinic nurses expressed that there was room for improvement; more could be done to increase the percentage of subsidies. They felt that the incentives were too low and not proportional to their level of effort. Manongi, Mushi, Kessy, Salome and Njau (2014:11) agree that low incentives are an impediment to effective implementation of various RBF programmes.

The majority of nurses cited indicator prices, indicator price discrepancy, limited financial autonomy, reimbursement criteria and the effects of low volume population on reimbursements as primary challenges to effective implementation of the RBF model. They compared outpatient department indicator prices between districts managed by Cordaid and themselves, and the discrepancy was substantial. Paul et al (2014:7) also indicates that multiple indicator pricing that exists among various RBF programmes caused discontent between staff who worked for the different programmes. The biggest challenge seemed to be high workload and selective payments.

#### **5.3.4 Theme 4: Strengthening implementation of RBF**

Nurses made several suggestions to modify the organisational components of RBF and to minimise the hurdles that hinder its implementation. The ultimate aim was to create enabling environments for nurses working within a funding model. It was critical to elicit recommendations from participants as they had experience dealing with the RBF model.

#### **5.3.4.1 Subtheme 4.1: Improving the organisation of RBF**

Rural health facilities' nurses recommended a revision of criteria for indicator payment for ANC bookings; to pay for all bookings, irrespective of the time of registration. They also believed that RBF authorities should develop mechanisms to accelerate subsidy payments to health facilities, to support clinical and administrative operations. Participants expressed the need to review the current funding structure to include the district hospitals.

Council clinic nurses emphasised a review of indicator prices and staff incentives. They stated that indicator prices should be uniform across all RBF programmes in Zimbabwe. Additionally, they recommended that support staff and village health workers should also be awarded some incentives, including non-monetary incentives. Abduljawad and Al-Assaf (2011:5) found that recognition was a more important incentive for professionals.

Council clinic nurses recognised the need to raise community awareness and to encourage them to utilise health care services. This predominantly referred to early ANC bookings and clinic deliveries. Nurses assumed that this would encourage community responsiveness to health care and generate more incentives. Furthermore, council clinic nurses recommended that funders should pay a fixed subsidy to health facilities serving low catchment populations. They believed that fixed subsidies could promote horizontal equity of health care. In addition, the health authorities/managers should implement measures to retain nurses in rural areas. This would address the challenge of high workloads and potential burn-out.

Furthermore, they recommended a local resource mobilisation strategy to ensure sustainability. It appeared that nurses were aware of possibilities of unfinished narratives. They demonstrated a sense of responsibility for the health care system in their country.

#### **5.3.4.2 Subtheme 4.2: Reducing bureaucracy in operations**

Participants recognised the burden of procurement procedures currently in place and recommended that authorities should review procurement procedures with a view to reduce the paperwork and bureaucracy in the procurement processes. Finally, they believed that a certain measure of autonomy regarding subsidy utilisation was necessary. Studies conducted in the DRC indicated that one US dollar given in cash directly to a health facility with autonomous expenditure may have the same result as \$4 invested centrally through inputs such as hiring staff, medicines, equipment, and facilities (Soeters, Nkunzimana & Fritsche 2011:7).

### **5.4 RECOMMENDATIONS**

Based on the findings of the study, the researcher makes the following recommendations for policy related issues and further research.

#### **5.4.1 Recommendations for policy related issues**

The results revealed a need to review the organisation and implementation of RBF.

- Subsidies to rural health facilities serving low catchment populations should be standardised in recognition of the efforts nurses put into making RBF work.
- RBF should be included at district hospitals to facilitate continuum of care across the health care delivery system.
- Policy on health care financing should be developed using local resources and the eventual withdrawal of donor funding should be anticipated and planned for.
- A payment cycle should be designed for subsidy reimbursement with strict timelines to reduce delays in payments.
- Socio-cultural realities in funding structures should be recognised.

- Professional nurses should be involved in designing, planning and reviewing RBF programmes.
- Financial autonomy for rural health facilities implementing RBF should be increased.
- Environmental health technicians should be employed at all health facilities as well as support staff ; namely, general hand, nurse aid and security guard for all low-earning facilities that currently do not have support staff.
- Procurement guidelines used in the RBF programme should be reviewed.
- Health centre committees should be assigned to deal with procurement issues for health facilities.
- Village health workers should be incentivised on the RBF programme.

#### **5.4.2 Recommendations for further research**

The study recommends further research in the following areas:

- Qualitative research on cultural barriers to early ANC bookings in rural communities, to identify the underlying factors and the impact on health outcomes.
- Case studies on other developing countries reporting successes in performance-based incentive models.
- Explore alternative ways to implement local health care financing models.
- Qualitative research on financial incentives for RBF to strengthen intrinsic motivation that is vital for positive attitudes and commitment to work.

- A quantitative study to measure the impact of a lack of continuum of care. This may help generate evidence that support decisions to include district hospitals in RBF to close the gap between primary and secondary levels of health care.

## **5.5 CONTRIBUTIONS OF THE STUDY**

This study has provided a clear depiction of the organisation of RBF in Zimbabwe as perceived and experienced by nurses. A basis for further inquiry into measures that could strengthen the implementation of RBF was also discussed. Several factors that supported effective implementation and those that were found to be a hindrance were highlighted. The knowledge generated from the nurses could provide health policy makers with insights on how the financing model is experienced by the professionals charged with its implementation. The study emphasised several measures that could be used to strengthen the implementation of donor funds, and it is believed that these measures will enhance nurses' work experience and improve health outcomes. More importantly, if the recommendations are accepted, there will be plans to sustain the positive outcomes achieved from the funding model.

Developing countries are often accused of a dependency on foreign aid. However, this study revealed nurses who were committed to sustainability of the quality work they were providing. They demonstrated a sense of obligation towards their patients and the country. They had foresight to think of the continuity of their work.

The findings were significant in revealing that an improved RBF could strengthen health care delivery and enhance health outcomes.

## **5.6 LIMITATIONS OF THE STUDY**

The following limitations of the study were noted. The study focused only on nurses' views and experiences regarding implementation of the RBF model in one district in Mashonaland East Province. As such, a similar study in another setting could produce different findings. However, in qualitative research, researchers do not primarily seek to generalise the findings. In this study, the researcher sought an understanding that might prove useful in other similar settings.

## **5.7 CONCLUSION**

The majority of nurses used their experiences to interpret the implementation of RBF in Zimbabwe. They viewed their roles as pivotal in its successful implementation. There was a high level of consensus among them regarding the successes and challenges of the healthcare funding model. This shed more light on understanding the organisational aspects of RBF in Zimbabwe. Participants unanimously agreed that the RBF focuses on maternal and child health care, there is a link between outputs and payments, and the importance of proper documentation and quality. Nurses showed appreciation for the incentives attached to the funding model, although it meant increased workloads. They recognised the increase in motivation and confidence, improvements in the infrastructure, resources, and improved health outcomes such as a reduction in IMR and MMR. However, they lamented the shortage of staff that resulted in high workloads. The study observed some tension between the need for high reimbursements and the challenge of high workload. Since RBF is based on quantity, they needed to work harder on indicators that brought higher incentives; they earned money for themselves and to improve the health facility. Yet, this led to increased workloads.

The findings revealed several challenges hindering the optimum implementation of RBF in Zimbabwe. These included low indicator prices, indicator price discrepancy, low catchment populations, delays in subsidy payments, and exclusion of district hospitals from RBF. These were viewed as regressive. Nurses had full understanding of the processes involved in the implementation of RBF; they demonstrated commitment to its success as shown by their concern regarding its sustainability. Their experiences were well articulated and reflected the complexities of foreign aid.

## LIST OF REFERENCES

- Abduljawad, A. & Al-Assaf, A.F. 2011. Incentives for better performance in health care. *Pub Med Journal*, 11(2):201-206. Available from: <https://www.ncbi.nlm.nih.gov/pubmed/21969891>. (Accessed 13 May 2016).
- Africa Health Forum. 2013. Finance and Capacity for Results. *Discussion paper*. Available from: <http://www.worldbank.org/en/events/2013/04/18/africa-health-forum-2013-finance-and-capacity-for-results> (Accessed 19 July 2016).
- Antony, M., Bertone, M.P. & Barthes, O. 2017. Exploring implementation practices in results-based financing: the case of the verification in Benin. *BMC Health Services Research Journal*, 17(1):204-209. Available from: <https://www.ncbi.nlm.nih.gov/pubmed/28288637>. (Accessed 27 May 2017).
- Ataguba, J.E. & Akazili, J. 2010. Health care financing in South Africa: moving towards universal coverage. *Continuuing Medical Education Journal*, 28(2):74-82. Available from: <http://www.cmej.org.za/index.php/cmej/article/view/1782>. (Accessed 7 October 2016).
- Babbie, E. & Mouton, J. 2012. *The practice of social research*. 14<sup>th</sup> edition. Cape Town: Oxford University Press.
- Basinga, P. 2011. Effect on maternal and child health services in Rwanda payment to primary health-care providers for performance: an impact evaluation. *Lancet Journal*, 11(8):177-183. Available from: <http://www.thelancet.com/article/S0140-6736>. (Accessed 1 June 2016).
- Brink, H., van der Walt, C. & van der Rensburg, G. 2012. *Fundamentals of Research Methodology for Healthcare Professionals*. 3<sup>rd</sup> edition. Cape Town: Juta.

- Brenner, S., Muula, AS., Robyn, PJ., Barnighausen, T., Sarker, M., Mathanga, DP., Bossert, T. & De Allegri, M. 2014. Design of an impact evaluation using a mixed methods model – an explanatory assessment of the effects of results-based financing mechanisms on maternal healthcare services in Malawi. *Global Health Journal*, 14(10):180-186. Available from: <https://bmchealthservres.biomedcentral.com/articles/10.1186/1472-6963-14-180>. (Accessed 21 November 2017).
- Burns, N. & Grove, S.K. 2011. *Understanding nursing research: building an evidence-based practice*. 5<sup>th</sup> edition. Missouri: Elsevier Saunders.
- Chimhutu, V., Lindsvik, I. & Lange, S. 2014. When incentives work too well: locally implemented pay for performance (P4P) and adverse sanctions towards home birth in Tanzania - a qualitative study. *BMC Health Services Research Journal*, 11(38):125-129. Available from: <https://www.ncbi.nlm.nih.gov/pubmed/26330198>. (Accessed on 7 August 2017).
- Clarke, S.P., Raphel, C. & Disches, J. 2008. Challenges and Directions for Nursing in the Pay-for-Performance Movement. *PMC Journal*, 9(2):127-134. Available from: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2697611/>. (Accessed 21 May 2016).
- Cordaid 2013. RBF. Available from: [www.rfb.org](http://www.rfb.org). (Accessed on 28 August 2016).
- Creswell, J.W. 2014. *Research design: Qualitative, quantitative, and mixed methods approach*. 4<sup>th</sup> edition. Thousand Oaks: Sage.
- De Vos, A.S., Strydom, H., Fouche, C.B. & Delport, C.S. 2014. *Research at grassroots for social sciences and human services professional*. 5<sup>th</sup> edition. Pretoria: Van Schaik.
- Eichler, R., Agarwal, K., Askew, A., Iriate, K., Morgan, L. & Watson, J. 2013. Performance-based incentives to improve health status of mothers and newborns: what does the evidence show? *Pub Med Journal*, 4(2):36-47.



Available from: <https://www.ncbi.nlm.nih.gov/pubmed/24992802>. (Accessed 12 February 2016)

Elumah, L.O., Ibrahim, O.M. & Shobayo, P.B. 2016. The Impact of Financial and Moral Incentives on Organizational Performance: A Study of Nigerian Universities. *Arabian Journal of Business and Management Review*, 6(5):2223-5833. Available from: <https://www.omicsonline.org/open-access/the-impact-of-financial-and-moral-incentives-on-organizational-performancea-study-of-nigerian-universities-2223-5833-1000255.php?aid=80205>. (Accessed 15 November 2017).

Gilson, L. 2016. *Complex Health Systems Lecture*. University of the Western Cape. (28 June 2016).

Goetz, K., Marx, M., Marx, I., Brodowski, M., Nafula, M., Prytherch, H., Awour, O.I.K. & Szecsenyi, J. 2015. Working Atmosphere and Job Satisfaction of Health Care Staff in Kenya: *An Exploratory Study*. Available from: Error! Hyperlink reference not valid.. (Accessed 15 June 2017).

Grittner, A.M. 2013. Results Based Financing. Evidence from Performance-Based Financing in the Health Sector. *Discussion paper*. Bonn.

Grove, K., Gray, R. & Burns, N. 2015. *Understanding Nursing Research: Building an evidence-based practice*. 6<sup>th</sup> edition. St Louis: Elsevier.

Gunda, C., Mubaira, C. & Maradzika, J. 2013. *RBF Training Manual*. University of Zimbabwe.

Hornby, A.S. 2015. *Oxford Advanced Learners' Dictionary International Students Edition*. 9<sup>th</sup> edition. Oxford University Press

- Ir, P., Korachais, C., Chheng, K., Horemans, D., Van Damme, W. & Meesen, B. 2015. Boosting facility deliveries with results-based financing: a mixed-methods evaluation of the government midwifery incentive scheme in Cambodia. *Pub Med Journal*, 15(15):170-177. Available from: <https://www.ncbi.nlm.nih.gov/pubmed/26276138>. (Accessed 14 February 2017).
- Kaufmann, W. & Tummers, L. 2016. The negative effect of red tape on procedural satisfaction. *Public Management Review Journal*, 19(9):1311-1327. Available from: <http://www.tandfonline.com/doi/abs/10.1080/14719037.2016.1210907>. (Accessed 19 October 2017).
- Kavanagh, T.K., Cimiotti, J.P., Abusalem, S. & Coty, M.B. 2012. Moving Healthcare Quality Forward With Nursing-Sensitive Value-Based Purchasing. *Journal of nursing scholarship*, 44(4):385-395. Available from: 10.1111/j.1547-5069.2012.01469.x. (Accessed 16 June 2016).
- Klynveld Peat Marwick Goerdeler (KPMG).2012. *Discussion paper*. Africa.
- Kulesher, R. & Forrestal, E. 2014. International models of health systems financing. *Journal of Hospital Administration*, 3(4):127-130. Available from: <http://www.sciedu.ca/journal/index.php/jha/article/view/4153/2853>. (Accessed 21 October 2017).
- LoBiondo-Wood, G. & Haber, J. 2010. *Nursing research: methods and critical appraisal for evidence-based practice*. 7<sup>th</sup> edition. St Louis: Mosby.

- Makoni, E., Tsikirayi, CM., Urombo, J. & Vushoma, E. 2014. Effectiveness of the performance based financing (PBF) model: An assessment of experiences from the Zimbabwean health sector (2011 – 2013). *Prime Journal of Business Administration and Management*, 4(5):1463-1477. Available from: <https://www.primejournal.org/BAM/abstracts/2014/may/Makoni%20et%20al.htm>. (Accessed 20 October 2017).
- McCunes, S. 2014. Performance-Based Financing in Kenya: Motivating Health Workers and Spurring Change. World Bank. Available from: <http://www.rbhealth.org/resource/performance-based-financing-kenya-motivating-health-workers-and-spurring-change>. (Accessed on 16 June 2016).
- Ministry of Health & Child Care. 2013. *National Health Strategy*. Harare. Government Printer.
- Ministry of Health & Child Care. 2014. *National Results Based Financing Approach: Project Implementation Manual*. Harare. Government Printer.
- Ministry of Health & Child Care. 2017. Revised *National Results Based Financing Approach: Project Implementation Manual*. Harare. Government Printer.
- Mukuna, A.N., Mwaura-Tenambergen, W. & Adoyo, M. 2015. Role of Nurses in Reducing Health Care Costs in a Faith Based Health Institutions: A Case of PCEA Tumutumu Hospital, Kenya. *The Journal of Global Health Systems* 5 (3): [404-411]. Available from: <http://jghcs.info/index.php/j/article/view/404>. (Accessed 23 October 2017).

- Murewa District Council 2016. Available from: <http://murewardc.org.zw/>. (Accessed 14 June 2016).
- Nakhimovsky, S., Langenbrunner, J., White, J., Vogus, A., Zelelew, H. & Avila, C. 2014. *Domestic Innovative Financing for Health: Learning From Country Experience*. USAID Report.
- Nursing Act (Acts 1 of 1974 and 16 of 1999). Available from: <http://moh.gov.ms/wp-content/uploads/2008/11/nurses-and-midwives-act.pdf>. (Accessed 19 July 2016).
- Niyonkuru, F. 2016. Failure of Foreign Aid in Developing Countries: A Quest for Alternatives. *Business and Economics Journal*, 7(213):2151-6219. Available from: <https://www.omicsonline.org/open-access/failure-of-foreign-aid-in-developing-countries-a-quest-for-alternatives-2151-6219-1000231.php?aid=80040>. (Accessed 15 November 2017).
- Paul, E., Sossouhounto, N. & Eclous', D.S. 2014. Local Stakeholders' Perceptions about the Introduction of Performance-Based Financing in Benin: A Case Study in Two Health Districts. *International Journal of Public Health and Management*, 3(4):207-214. Available from: [http://ijhpm.com/article\\_2892\\_607.html](http://ijhpm.com/article_2892_607.html). (Accessed 12 June 2016).
- Polit, D.F. & Beck, C.T. 2010. *Essentials of Nursing research. Appraising evidence for nursing practice*. 7<sup>th</sup> edition. Philadelphia: Lippincott.
- Polit, D.F. & Beck, C.T. 2012. *Nursing research. Generating and assessing evidence for nursing practice*. 9<sup>th</sup> edition. Philadelphia: Lippincott.
- Robert wood Johnson Foundation. 2015. *Nurses Take on New and Expanded Roles in Health Care*. Available from: <https://www.rwjf.org/en/library/articles-and-news/2015/06/rwjf-announces-2015-sports-award-finalists.html>. (Accessed 14 February 2017).

- Rudasingwa, M. & Uwizeye, M.R. 2017. Physicians' and nurses' attitude towards based financial incentives in Burundi: A qualitative study in the province of Gitega. *Global Health Action Journal*, 10(1):10-13. Available from: <http://dx.doi.org/10.1080/16549716.2017.1270813>. (Accessed on 24 February 2016).
- Saldana, J. 2011. *Fundamentals of qualitative research: understanding research*. New York: Oxford University press. Available from: <http://site.ebrary.com.oasis.unisa.ac.za>. (Accessed on 20 June 2016).
- Schoffelen, E., van de Looij, F., Rusakaniko, S. & Mhlanga, R. 2016. *Training Manual Results Based Financing for Policy makers*. 1<sup>st</sup> edition. University of Zimbabwe.
- Sieleumou, S., Tremblay, C. & Taptue-Fotso, J.C. 2017. Community Results-based financing in health practice: *Reflections on implementation from experiences in six countries*. Available from: <https://openknowledge.worldbank.org/handle/10986/27462>. (Accessed 23 August 2017).
- Sithole, A. 2013. Results Based Financing in Zimbabwe: Any Changes in the Health Delivery System. *Journal of Social Welfare and Human Rights*, 1(1):36-46. Available from: <http://jswhr.com/vol-1-no-1-june-2013-abstract-3-jswhr>. (Accessed 7 March 2017).
- Soeters, R., Nkunzimana, C. & Fritsche, G. 2011. The Indices management tool for use in performance based financing: *taking a closer look inside the black box of health facility autonomy, efficiency and performance*. Available from: <http://siteresources.worldbank.org/extpbftoolkit/resources/7364043-1386179808313>. (Accessed 16 August 2016)
- Streubert, H., Speziale, H.J. & Carpenter, D.R. 2011. *Qualitative research in nursing: advancing the humanistic imperative*. 5<sup>th</sup> edition. Philadelphia: Lippincott Williams & Wilkins.

- Swanson, R.C., Atun, R., Best, A., Betigere, A., de Campos, A., Chunharas, S., Collins, T., Curie, G., Jan, S., McCoy, D., Omaswa, F., Sanders, D., Sandararaman, T. & Van Damme, T. 2015. Strengthening health systems in low-income countries by enhancing organizational capacities and improving institutions. *PMC Journal*, 11(5):10-23. Available from: <https://www.ncbi.nlm.nih.gov/pubmed/25890069>. (Accessed 29 September 2016)
- Tappen, R.M. 2011. *Advanced nursing research from theory to practice*. Sudbury; M.A: Jones & Bartlett Learning.
- The National Health Strategy for Zimbabwe. 2016-2020. *Equity and Quality in Health: Leaving no one behind*. Government printer.
- United States for International Development. 2015. *Discussion paper*. Funding.
- Van de Looiji, F., Mureyi, D., Sisimayi, C., Koot, J., Manangazira, P. & Musuka, N. 2015. Early evidence from results-based financing in rural Zimbabwe. *Africa Health Monitor Journal*, 1(20):32-36. Available from: <http://www.aho.afro.who.int/en/ahm/issue/20/articles/early-evidence-results-based-financing-rural-zimbabwe>. (Accessed 14 June 2016).
- Wilhem, D.J., Brenner, S., Muula, A.S. & Allegri, M. 2016. A qualitative study assessing the acceptability and adoption of implementing a results based financing intervention to improve maternal and neonatal health in Malawi. *BMC Journal*, 16(1):398-412. doi: 10.1186/s12913-016-1652-7 (Accessed 23 August 2016).
- Witter, S., Zulfiquir, T., Javeed, S., Khan, A. & Bari, A. 2011. Paying health workers for performance in Battagram district, Pakistan. Available from: Error! Hyperlink reference not valid.. (Accessed September 2016).

- Wilson, A., Whitaker, N. & Whitford, D. 2012. Rising to the Challenge of Health Care Reform with Entrepreneurial and Intrapreneurial Nursing Initiatives. *PubMed Journal*, 17(2):5-17. Available from: <https://www.ncbi.nlm.nih.gov/pubmed/22686113>. (Accessed 23 June 2016).
- World Bank 2014. *RBF*. Available from: <https://www.rbf.org>. (Accessed 14 May 2016).
- World Bank. 2013. *Health Financing*. Available from: <https://www.health.financing.org> (Accessed 14 March 2016).
- World Health Organisation. 2013. *Africa Health Forum Finance and Capacity for Results Summary Report*. Washington DC.
- Ye, M., Diboulo, E., Kagone, M., Sie, A., Sauerborn, R. & Loukanova, S. 2016. Health worker preferences for performance-based payment schemes in a rural health district in Burkina Faso. *Global Health Action Journal*, 9(29):103-119. Available from: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4703797/>. (Accessed 29 December 2016).

# ANNEXURE A: UNIVERSITY OF SOUTH AFRICA ETHICAL CLEARANCE



## RESEARCH ETHICS COMMITTEE: DEPARTMENT OF HEALTH STUDIES REC-012714-039 (NHERC)

2 November 2016

Dear Mr P Nyabani

**Decision: Ethics Approval**

**HSHDC/556/2016**

Mr P Nyabani

Student: 5853-130-0

Supervisor: Dr MM Ramukumba

Qualification: PhD

Joint Supervisor: -

**Name:** Mr P Nyabani

**Proposal:** Nurses' views and experiences regarding implementation of results based financing in Zimbabwe.

**Qualification:** MPCHS94

Thank you for the application for research ethics approval from the Research Ethics Committee: Department of Health Studies, for the above mentioned research. Final approval is granted for the duration of the research period as indicated in your application.

*The application was reviewed in compliance with the Unisa Policy on Research Ethics by the Research Ethics Committee: Department of Health Studies on 2 November 2016.*

*The proposed research may now commence with the proviso that:*

- 1) The researcher/s will ensure that the research project adheres to the values and principles expressed in the UNISA Policy on Research Ethics.*
- 2) Any adverse circumstance arising in the undertaking of the research project that is relevant to the ethicality of the study, as well as changes in the methodology, should be communicated in writing to the Research Ethics Review Committee, Department of Health Studies. An amended application could be requested if there are substantial changes from the existing proposal, especially if those changes affect any of the study-related risks for the research participants.*



Open Rubric

University of South Africa  
Preller Street, Muckleneuk Ridge, City of Tshwane  
PO Box 392 UNISA 0003 South Africa  
Telephone: +27 12 429 3111 Facsimile: +27 12 429 4150  
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3) *The researcher will ensure that the research project adheres to any applicable national legislation, professional codes of conduct, institutional guidelines and scientific standards relevant to the specific field of study.*

4) *[Stipulate any reporting requirements if applicable].*

*Note:*

*The reference numbers [top middle and right corner of this communiqué] should be clearly indicated on all forms of communication [e.g. Webmail, E-mail messages, letters] with the intended research participants, as well as with the Research Ethics Committee: Department of Health Studies.*

Kind regards,



Prof L Roets  
CHAIRPERSON  
[roetsl@unisa.ac.za](mailto:roetsl@unisa.ac.za)



Prof MM Moleki  
ACADEMIC CHAIRPERSON  
[molekmm@unisa.ac.za](mailto:molekmm@unisa.ac.za)

# ANNEXURE B: MEDICAL RESEARCH COUNCIL OF ZIMBABWE

## ETHICAL CLEARANCE CERTIFICATE

Telephone: 791792/791193  
Telefax: (263) - 4 - 790715  
E-mail: [mrcz@mrcz.org.zw](mailto:mrcz@mrcz.org.zw)  
Website: <http://www.mrcz.org.zw>



Medical Research Council of Zimbabwe  
Josiah Tongogara / Mazoe Street  
P. O. Box CY 573  
Causeway  
Harare

### APPROVAL LETTER

REF: MRCZ/B/1224

10 February, 2017

Prosper Nyabani  
6 Laing Crescent, Craneborne  
Harare  
Zimbabwe

#### RE: NURSE'S VIEWS AND EXPERIENCES REGARDING IMPLEMENTATION OF RESULTS BASED FINANCING (RBF) IN ZIMBABWE.

Thank you for the above titled proposal that you submitted to the Medical Research Council of Zimbabwe (MRCZ) for review. Please be advised that the Medical Research Council of Zimbabwe has **reviewed** and **approved** your application to conduct the above titled study. This is based on the following documents that were submitted to the MRCZ for review:

- a) Study proposal
- b) Questionnaires
- c) Informed Consent Forms

#### APPROVAL NUMBER

: MRCZ/B/1224

This number should be used on all correspondence, consent forms and documents as appropriate.

- **APPROVAL DATE** : 10 February, 2017
- **TYPE OF MEETING** : Expedited
- **EXPIRATION DATE** : 09 February, 2018

After this date, this project may only continue upon renewal. For purposes of renewal, a progress report on a standard form obtainable from the MRCZ Offices should be submitted one month before the expiration date for continuing review.

- **SERIOUS ADVERSE EVENT REPORTING:** All serious problems having to do with subject safety must be reported to the Institutional Ethical Review Committee (IERC) as well as the MRCZ within 3 working days using standard forms obtainable from the MRCZ Offices.
- **MODIFICATIONS:** Prior MRCZ and IERC approval using standard forms obtainable from the MRCZ Offices is required before implementing any changes in the Protocol (including changes in the consent documents).
- **TERMINATION OF STUDY:** On termination of a study, a report has to be submitted to the MRCZ using standard forms obtainable from the MRCZ Offices.
- **QUESTIONS:** Please contact the MRCZ on Telephone No. (04) 791792, 791193 or by e-mail on [mrcz@mrcz.org.zw](mailto:mrcz@mrcz.org.zw).
- **Other**
- Please be reminded to send in copies of your research results for our records as well as for Health Research Database.
- You're also encouraged to submit electronic copies of your publications in peer-reviewed journals that may emanate from this study.

Yours Faithfully

MRCZ SECRETARIAT  
FOR CHAIRPERSON  
MEDICAL RESEARCH COUNCIL OF ZIMBABWE

PROMOTING THE ETHICAL CONDUCT OF HEALTH RESEARCH



## **ANNEXURE C: LETTER REQUESTING PERMISSION FROM THE MINISTRY OF HEALTH AND CHILD WELFARE**

6 Laing Crescent, Craneborne  
Harare  
Zimbabwe  
7 November 2016

Dr Gerald Gwinji (Brigadier Rtd)  
Permanent Secretary  
Ministry of Health and Child care  
Kaguvi Building  
Harare  
Zimbabwe

Dear Sir

### **RE: REQUEST FOR PERMISSION TO CONDUCT A RESEARCH**

I am currently studying towards Master of Public Health degree at the University of South Africa. I hereby request permission to conduct a research study in Murewa district, with nurses at facilities implementing Results Based Financing (RBF) model.

The title of the study is: **Nurses' views and experiences regarding implementation of Results Based Financing (RBF) in Zimbabwe.**

The purpose of the study is to explore nurses' views and experiences regarding the implementation of RBF in Zimbabwe. The expected outcome of this study is aimed at providing feedback for programme strengthening.

The research participants will be professional nurses implementing RBF in Murewa district. Data will be collected using unstructured focus groups with nurses from high medium low earning facilities.

**Attached are Supporting documents and an Ethical Clearance Certificate issued by the University of South Africa's Health Studies Department, Scientific and Ethics Committee.**

Ethical rights of participants will be observed during this study.

My research supervisor is Doctor Ramukumba MM, Department of Health Studies UNISA. Email: [ramukk@unisa.ac.za](mailto:ramukk@unisa.ac.za); telephone: +277 124 296 719.

My contact details: email: [prosperryabani@gmail.com](mailto:prosperryabani@gmail.com); cell: 0773 630 292 /0734 583 502

Yours faithfully

**Prosper Nyabani**

**Student number: 58531300**

## ANNEXURE D: LETTER OF APPROVAL FROM THE MINISTRY OF HEALTH AND CHILD CARE

Telephone: +263-4-798537/60  
Telegraphic Address:  
"MEDICUS", Harare  
Fax: +263-4-720119/702293  
Telex: MEDICUS 22211ZW



Reference:  
Ministry of Health and Child  
Welfare  
P O Box CY1122  
Causeway  
HARARE

23 January 2017

### To Whom It May Concern.

This letter serves to inform authorities that Mr Prosper Nyabani, student number 58531300, who is currently enrolled for a Master of Public Health degree with the University of South Africa (UNISA), has been granted permission to conduct a research study titled **"Nurses' views and experiences regarding implementation of Results Based Financing (RBF) in Zimbabwe"**.

Nurses who will participate in this study will be recruited from rural health facilities (mission clinics and rural hospitals, council clinics and government clinics) implementing Results Based Financing (RBF) in Murewa district, Mashonaland East Province, Zimbabwe. Murewa Hospital, a central and convenient venue, where nurses normally converge for monthly nurses' meetings will be used to conduct Focus Group Discussions (FGDs) with participants during this study.

This study will be conducted at Murewa Hospital, in Murewa district, Mashonaland East Province, Zimbabwe.

May you kindly co-operate and support him with all assistance necessary, during the course of the aforementioned study.



**Dr. R. F. Mudyiradima**

**Acting : Permanent Secretary for Child and Health Care**



## **ANNEXURE E: INFORMED CONSENT FOR PARTICIPANTS**

### **Nurses' views and experiences regarding implementation of Results Based Financing (RBF) in Zimbabwe**

Principal Investigator: Prosper Nyabani (Bsc)

Dear research participant: Consent to participate in a study.

I am an MPH student with University of South Africa (UNISA). I am conducting a research study titled **Nurses' views and experiences regarding implementation of Results Based Financing (RBF) in Zimbabwe**. You are invited to participate in the study project.

The purpose of the study is to explore nurses' views and experiences regarding the implementation of RBF in Zimbabwe. The proposed study will help the researcher to learn more about your views and experiences as professional nurses implementing the RBF model. The information obtained will result in knowledge and evidence useful in generating recommendations to Public Health Policy makers on how to strengthen implementation of the RBF model.

You are invited and requested to participate in the focus groups which will not take more than 2 hours. You will be required to answer questions during the focus group session. Focus group sessions will be audio-taped for the purpose of later transcriptions by the researcher.

Your participation will be voluntary, there are no risks involved and no compensation or material benefit will be given. All information will be treated as confidential and your anonymity is protected.

You may withdraw from participating in this study if you wish at any point in time without any consequences.

### Statement of Consent to be photographed, Audio-taped or Video-taped

I understand that photographs / audio recordings / video recordings will be taken during the study. *(For each statement, please choose YES or NO by inserting your initials in the relevant box)*

- I agree to **being audio recorded**

**Yes**

**No**

☐

Should you wish to contact the researcher for any enquiries, questions or comments do not hesitate to contact researcher at Prosper Nyabani, cell no. 0773 630 292.

I.....hereby voluntarily give consent to participate in the study.

Participant's signature..... Date.....



## ANNEXURE F: INTERVIEW GUIDE FOCUS GROUP DISCUSSION

### SECTION A: BIOGRAPHIC DATA

1. Sex:\_\_\_\_\_
2. Age:\_\_\_\_\_
3. Marital status:\_\_\_\_\_
4. Did you attend any Results Based Financing (RBF) training course?  
\_\_\_\_\_
5. Which programme did you complete towards registration as a Registered Nurse?  
\_\_\_\_\_
6. Years of experience as a Registered Nurse? \_\_\_\_\_
7. Years of experience implementing RBF?\_\_\_\_\_
- Professional \_\_\_\_\_ qualifications
8. Any Specialty qualifications? \_\_\_\_\_
9. What is the ownership of the facility were you work?  
\_\_\_\_\_

### SECTION B: GRAND TOUR QUESTIONS

“Tell me about RBF at your clinic in general”

- What are your views of the RBF model?
- How do you experience the RBF programme?

“What does implementing RBF model mean to you?”

- Tell me about your views regarding implementing this model?
- How do you implement the RBF model?
- What is the significance of RBF model?

- What is your role in ensuring successful implementation of RBF programme?
- What challenges do you face in implementing this model?
- How can RBF programme be strengthened?